University of Portland
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Release of Protected Health Information – Primary Care Services

STUDENT NAME: _____ STUDENT D.O.B.: _____

I authorize the University of Portland Health and Counseling Center to obtain, use, and/or disclose a copy of the specific protected health information (PHI) described below:

Release my protected health information to/ from _____
using the contact information provided below:

MAILING ADDRESS: _____

PHONE: _____ FAX: _____

Information consisting of *(check all that apply)*:
☐ Assessment ☐ Treatment ☐ Lab Results ☐ Record of Immunizations
☐ Other: _____

Purpose of release *(check all that apply)*:
☐ Request of Individual ☐ Care Coordination ☐ Facilitate Processing of Medical Leave of Absence
☐ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed only if I sign my initials in the applicable space next to the type of information**:

_____ HIV/AIDS information
_____ Genetic testing information
_____ Mental health information *(please specify)*: _____
_____ Drug/Alcohol diagnosis, treatment, or referral information *(please specify)*: _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

You are not obligated to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance in which refusal to sign would prevent you from receiving health care services, is in the case that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure (i.e. a referral to/from an outside provider).

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to the University of Portland Health and Counseling Center (contact information below) and state that you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires one year from the date of signature or the specified date of *(insert alternate expiration date):* _____

STUDENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE (if student is under 18): _____ DATE: _____

Please return this form via email (preferred), fax, or in-person to:

University of Portland Health and Counseling Center
5000 N Willamette Blvd.
Orrico Hall, upper level
Portland, OR, 97203

Email: hcc@up.edu
Phone: 503-943-7134
Fax: 503-943-7199