UNIVERSITY HEALTH CENTER
5000 North Willamette Boulevard
Portland, Oregon 97203-5798
(503) 943-7134 / Fax: (503) 943-7199
www.up.edu

University of Portland

Authorization to Obtain, Use, and/or Disclose Protected Health Information

Name: Date of Birth:

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

To/From (please circle either or both):

Mailing Address

Phone: Fax:

Consisting of (please be specific):

For the purpose of: **(please check all that apply)**:
☐ Assessment ☐ Treatment ☐ Care Coordination ☐ Request of Individual ☐ Facilitate Processing of Medical Leave of Absence
☐ Record of Immunizations ☐ Other (please specify): ____________________

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 place my ***initials*** in the applicable space next to the type of information.

_____ **HIV/AIDS information**

_____ **Mental health information (please specify: ____________________)**

_____ **Genetic testing information**

_____ **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 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 do not need 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 when refusal to sign means that you will not receive health care services is if 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.

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 purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to ____________________ (contact person) at the University Health Center, 5000 N. Willamette Blvd., Portland, OR 97203-5798 and state that you are revoking this authorization.

SIGNATURE
I have read this authorization and I understand it. Unless revoked, this authorization expires one year from the date of signature **or** specified date of ____________________ (insert an applicable date).

Client Signature (or personal representative): Date:

Witness Signature: Date: