University of Portland
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University of Portland

Release of Protected Health Information – Health & Counseling Center

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

I authorize the University of Portland Health & 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: (Name/Company/Agency)

MAILING ADDRESS: _____

PHONE: _____ FAX: _____

Purpose of release *(check all that apply)*:
☐ Client/Patient Request ☐ Care Coordination ☐ Medical Leave of Absence ☐ Other: _____

Medical Services *(check all that apply)* ☐ Chart Notes; date range: _____
☐ Lab Results ☐ Immunization Records ☐ Other: _____

Counseling Services *(check all that apply)* ☐ Chart Notes; date range: _____
☐ Assessment/Treatment ☐ Medication Management ☐ Other: _____

Additional permission is required to disclose any of the records or information listed below. If you want this information or these records disclosed, initial each line. **I understand and agree that the following will only be disclosed 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 fill out a Revocation Form and submit to the University of Portland Health & Counseling Center (contact information below).

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 & Counseling Centers
Orrico Hall, upper level
5000 N Willamette Blvd.
Portland, OR, 97203

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

Electronic Disclosure: Email is not a secure form of communication. Please consider this when writing/responding to emails, particularly with sensitive content. The confidentiality of the information contained within this Release may be compromised if it is sent over email.