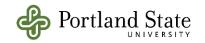


Patient Information & Consent

Center for Student Health & Counseling Portland State University Phone: 503.725.2800 Fax: 503.725.5812 1880 SW 6th Ave. Portland UCB Suite 200 PO Box 751 Portland, OR 97207



Release of Information Form

Student Name:	PSU ID#:	Date of Birth:		
A: I hereby consent and authorize the Center	for Student Health and Counseling	g to: (check one)		
Release my records to (proceed to section by Receive my records from (proceed to section Maintain verbal and written communication Recipient(s) of Records	on below)			
: Name of Individual or Organization: City/State/Zip:				
	Fax:			
Purpose of Information Release				
C: Records are being released for the purpose	of: (check at least one)			
Continuing Care Personal Records	☐ Insurance Review ☐ Legal Review	Other:		
Records to be Disclosed				
D: The records that are to be disclosed are: (c	heck all that apply)			
☐ Entire Medical Record ☐ Lab Reports ☐ Most Recent Annual & Pap	☐ Diagnostic Imaging Reports ☐ Pathology Report	☐ Entire Mental Health Record☐ Psychiatric Records☐ Other:		
E: If the information to be disclosed contains a use and disclosure of the information may appl INITIALS in the applicable space next to the ty	y. I understand and agree that th	nation listed below, additional laws relating to the is information will be disclosed if I place my		
HIV/AIDS Information Mental Health Information	Genetic Testing Information	Drug/Alcohol Diagnosis, Treatment or Referral Information		
Authorization and Consent to Release Rec	cords			
used or disclosed for the purposes described reliance on the authorization or the authoriz To revoke this authorization, please send a w Counseling, PO Box 751, Portland, OR 97207 You do not need to sign this authorization. F reimbursement for services. The only circum services are solely for the purpose of providing	in this written authorization. The only eation was obtained as a condition of obtavritten statement to the SHAC Medical Ref, and state that you are revoking this aut Refusal to sign the authorization will not a stance when refusal to sign means you ung health information to someone else a	ecords Coordinator at PSU's Center for Student Health and chorization. adversely affect your ability to receive health care services or will not receive health care services is if the health care nd the authorization is necessary to make that disclosure.		
F: By signing below, I acknowledge that I am authorities authorization will remain in effect for 365 days	prizing and consenting to the release of from the date it was signed.	or my medical records. Unless revoked in writing,		
CLICK FOR INSTRUCTIONS:	Date			

Official SHAC USE

Date Received/	_		
Date Mailed/Given/Faxed/	_/	(circle one)	
Comments/Reviewed For:			
Reviewer's Signature:			
OK to File (Date and Initial):			
Requesting Provider Name:	(check one)	Health Services:	Counseling Services: