☐	Pacific Dental Hygiene Clinic	☐	Pacific Ear Clinic	Clinic Location	
☐	Pacific Physical Therapists Clinic	☐	Pacific Eye Clinic	Clinic Address	
x	Pacific Psychology & Comprehensive Health Clinic	☐	Sports Medicine Clinic		

Pacific University
Oregon

Pacific University
AUTHORIZATION TO DISCLOSE HEALTH RECORDS

Name of Patient _____
Last First Middle

Other names (nicknames or maiden names) _____
Last First Middle

Mailing Address: _____

Date of birth: _____ Telephone: _____ OK to leave detailed message? ☐ Yes ☐ No

Healthcare Provider to **Release** Information:

Name Pacific Psychology & Comprehensive Health Clinic		
Address		
City Portland	State OR	Zip 97205
Phone 503-352-2400	Fax	

Person or Agency to **Receive** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Purpose of release: _____

If such information exists, I authorize the disclosure of ☐ the entire health record or ☐ the following specific documents, dates of service, and/or information about the following injury/illness/disease:

_____

The following items **must be initialed** to be released:

	HIV-positive test results and HIV diagnosis		Other sexually transmitted diseases (Washington only)
	Genetic testing information and/or records (Oregon only		
	Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed:		

- The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law.
- Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.
- Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.
- The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.
- The only circumstance when refusal to sign means the patient 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. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.
- I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on _____.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (If other than patient, proof of authority is required.) Relationship to Patient

Office Use Only: ID Verified by _____ Mail Records _____ Fax Records _____ Call to pickup _____

Reviewed: 1/14 ; Revised: 11/2017; 12/2018