AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Southern Oregon University holds patient health information and records, including treatment records. The privacy of these records is protected by one or more of the following: the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and Oregon's privacy laws (ORS Chapter 192). This document relates to authorization of the use and disclosure of health information and records in compliance with all applicable privacy laws.

I authorize Southern Oregon University to use and disclose an electronic copy or paper copy of the specific health information and records indicated below regarding:

_____ (name of patient)

to the following medical provider(s) or individual(s):
(select at least one provider or individual or insert your own name and information to receive your own records)

_____ La Clinica Del Valle Family Health Care Center (La Clinica) (name),
560 Indiana St., Ashland, OR 97520 (address) _____ (phone)

_____ _____ (name)
_____ (address) _____ (phone)

The health information and records indicated below will be used or disclosed for the purpose of:
(select at least one of the following)

_____ The continuity of my health care due to SOU's closure of its health care practice at its Student Health & Wellness Center.

_____ The use and disclosure is at my request without regard to the purpose.

My authorization for SOU to use and disclose to the provider(s) or individual(s) indicated above relates to the following health information and records.
(*write your initials in the space* next to the health information you are requesting)

_____ **All health information and records** in SOU Health Center's possession, including all of the health information and records listed below.

OR

_____ Physical exams and procedures (including gynecological)
_____ Medical history and clinical/medical chart notes
_____ Emergency and urgent care records
_____ Laboratory reports
_____ Diagnostic imaging reports (including X-rays, MRIs)
_____ Pharmacy records (including refillable prescriptions)
_____ Other (please specify information and date(s), if applicable)

_____ Vaccinations
_____ Contraception records
_____ Physical therapy records
_____ All hospital records
_____ Pathology reports
_____ Billing records

_____

_____

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

_____ HIV/AIDS information

_____ Genetic testing information

_____ Mental health information, including psychotherapy notes

_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and 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 (including psychotherapy notes), genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to agree to this authorization. Refusal to agree to the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to agree means 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, such as SOU, La Clinica, or another health care provider, has already taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please submit a written statement by secure upload at go.sou.edu/health-records-request and state that you are revoking this authorization.

APPLICABILITY OF FERPA: If your health information and records are protected by FERPA, they will no longer be protected by FERPA after disclosure. However, if your health records are provided to a health care provider, they will still be protected by HIPAA after disclosure.

ADDITIONAL IDENTIFYING INFORMATION: Please provide the following additional identifying information to assist SOU in retrieving your records.

_____ Phone Number _____ SOU ID Number _____ Date of Birth

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires upon SOU's destruction of my health information and records in accordance with state and federal records laws.

By: _____
(individual or personal representative)

Date: _____

Description of personal representative's authority (e.g., parent or guardian):

_____