LCC Health Clinic Release of Information Authorization Form

Patient's Name: _____ Date of Birth: _____ ID/Chart No: _____

I hereby authorize the use and disclosure of individually-identifiable health information relating to me, and records containing such information, as described below:

_____**Release Records TO LCC Health Clinic** *OR* _____**Request Records FROM LCC Health Clinic**

Lane Community College **Health Clinic** 4000 East 30th Avenue Building 18, Room 101 Eugene, Oregon 97405 Phone: (541) 463-5665 Fax: (541) 463-4164	Name:_____ Address:_____ City/State/ZIP:_____ Phone:_____ Fax:_____ Attention:_____

PURPOSE OF RELEASE:

___ Continued Medical Care ___ Insurance Purposes

___ Student Assistance ___ Other (Please specify):_____

RECORDS TO BE RELEASED:

___ **A Complete Copy of My Patient File** ___ Other (Please specify):_____

___ Clinician Chart Notes ___ Immunizations ___ Physical ___ Laboratory Reports ___ X-Ray Reports

******SPECIAL AUTHORIZATION REQUIRED**: You **MUST** initial (if you want the following records released)****

___ HIV/AIDS related ___ Mental Health ___ Alcohol & Chemical Dependency Treatment ___ Genetic Testing

You do not need to sign this authorization. Your treatment, payment, enrollment, or eligibility for benefits will not be conditioned on your signing 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 will mean you will not receive health services is if the health 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, by sending a written statement to the LCC Health Clinic at the address above. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Revocation will not affect any actions taken by LCC Health Clinic before receiving your revocation.

I understand that the information used or disclosed pursuant to this authorization may be re-released by the recipient and no longer protected by Federal or State privacy regulations. However, I also understand that federal or state law may restrict re-disclosure of information relating to HIV/AIDS, mental health, genetics, and drug/alcohol diagnosis, treatment or referrals.

By signing below, I acknowledge that I am authorizing and consenting to the release of my medical records. I have read this authorization and I understand it.

Unless revoked, this authorization expires one year after signing ***or*** (other expiration):_____

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient (Description of personal representative's authority): _____

To request this information in an alternate format please contact the Center for Accessible Resources at (541) 463-5150 or accessibleresources@lanecc.edu