Lewis & Clark

615 S. Palatine Hill Road
Portland, Oregon 97219
Phone 503-768-7000
lclark.edu

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Student Counseling Center MSC 135 | FAX 503-768-8223 | Phone 503-768-7160

Name:_____ Student ID#: _____DOB:_____

By initialing below, I hereby consent and authorize the Lewis & Clark Student Counseling Center Staff to:
(Please Initial)
_____ Send a copy of my specific health information to person or organization named below
_____ Receive a copy of my specific health information from person or organization named below
_____ Verbally exchange my specific health information with person or organization named below

TO/FROM:

Name _____

Address _____

Telephone _____ Fax _____

FOR THE PURPOSE OF: ☐ Coordination of Care ☐ Other (*Describe each purpose of disclosure*):

_____

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

(Please Initial)
_____ **Mental health information**
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ HIV/AIDS information
_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the receiving party and no longer be protected under 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.

PROVIDER INFORMATION
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive counseling services. The only circumstance when refusal to sign means you will not receive counseling services is if the 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 an entity has taken action in reliance on the authorization.

To revoke this authorization, please send a written statement to Dr. Robin Keillor, Associate Vice President of Student Health & Well-Being (MSC 135—Counseling) at Lewis & Clark College 615 S Palatine Hill Rd, Portland, OR 97219, and state that you are revoking this authorization.

SIGNATURE
I have read this authorization and I understand it. Unless revoked, this authorization expires at the end of the current academic year (May 31).

By: _____Date: _____ Your Phone Number:_____
(*Signature of Individual*)