CORBAN UNIVERSITY
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Salem, OR 97317-9392
Phone: 503.375.7010
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Comprehensive Student Health and Disability Report

CONFIDENTIAL INFORMATION RELEASE FORM

Please check box(s) indicating department(s) to send/receive information:

❑ Health Services ❑ Counseling Services ❑ Academic / Disability Services

Name: _____ Date of Birth: _____

I authorize the Corban University: ❑ To obtain and/or ❑ To release information as indicated below:

Name of Person and/or Department: _____

Mailing Address: _____

Phone: _____ Fax: _____

The purpose of this authorization is: ❑ Assessment ❑ Treatment ❑ Other: _____

By initialing below, I specifically authorize the release of the following information. (Information may be transmitted via photo-copied records; fax; and/or verbal communication unless noted otherwise below.)

MEDICAL/PHYSICAL HEALTH

_____ All Medical Records*
_____ Chart Notes
_____ Laboratory/Pathology Reports
_____ Diagnostic Imaging Reports
_____ Medications
_____ Immunizations
_____ *HIV / AIDS Related Test Results and Info.
_____ Information Specific to: _____

MENTAL HEALTH/COUNSELING

_____ All Medical Records*
_____ Chart Notes and Treament Planning
_____ Assessment *(Diagnosis, Testing Data, Summary Reports)*
_____ Psychiatric *(Notes, Medications, Referrals)*
_____ *Drug and Alcohol *(Assessment / Diagnosis Treatment, Recommendations, Referraks)*
_____ Information specific to accommodations

*If part of the information to be released includes HIV and/or Alcohol and drug information, the client must specifically initial the corresponding section in order to comply with federal and state regulations.

Specific conditions or limitations of the information to be released include: _____

I understand that my records are protected under federal confidentiality regulations (including alcohol and drug and HIV disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obliged to sign this consent form and that I may revoke this authorization at any time with the exception of action already taken based on previous approval.

This authorization will expire within one year of the date signed or on: _____

Client Signature *(or Legal Guardian)*: _____ Date: _____

Witness Signature: _____ Date: _____

Release Revoked: ❑ Date: _____ Initials: _____