AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION
Please mail, e-mail, or fax completed form to:
ISHC, 3201 Campus Drive, Klamath Falls, OR
Phone: 541.885.1800 | Fax: 541.885.1866 | email: health@oit.edu

In order to comply with your release request, please fill out this form carefully and completely! Much of the information is REQUIRED by federal and state law. Patient/representative may be charged a fee to complete the release of medical
information authorization below.
Patient Name:____ Other Names Used:_______________________

Current Address:____ Date of Birth:_____________________

Phone:_____________________________ Student ID: 918-_________________________ Last fo ET 1 0 0 1 297.17 632.62 Tm 0 G [(__