Siskiyou Community Health Center

AUTHORIZATION TO EXCHANGE VERBAL HEALTH INFORMATION

PATIENT INFORMATION: *(Please print)*

Name: _____

Date of Birth: _____ Type of ID: _____

EXCHANGE INFORMATION TO:

Name: _____

Date of Birth: _____ Type of ID #: _____

Relationship: _____

INFORMATION TO BE DISCLOSED:

Initial all that apply.

_____ Medical Chart Notes	_____ Hospital Reports	_____ Dental Chart Notes
_____ Diagnostic Results	_____ Immunization	_____ Perio Chart
_____ Lab/Pathology	_____ Specialist Consults	_____ Radiographs
_____ Medication	_____ Billing	_____ Appointment info.

This authorization may be revoked at any time by giving written notice to the Siskiyou Community Health Center. Such notice will be effective immediately upon receipt by Siskiyou Community Health Center records personnel. This content will be valid up to one (1) year.

Date of Consent: _____ Date consent expires: _____

Signature: _____ **Date:** _____

I recognize that the information disclosed may contain information that is protected by federal and state laws (i.e. Drug/Alcohol Abuse, Mental Health, HIV/AIDS), and I specifically consent to the disclosure of such information.

Initial each one that applies:

_____ HIV/AIDS
_____ Mental Health
_____ Drug/Alcohol Abuse

Signature: _____ **Date:** _____