Siskiyou Community Health Center

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____ Type of ID: _____

Healthcare Provider to ***Release*** Information:

☐ **Name**
Siskiyou Community Health Center (SCHC)
1701 NW Hawthorne Ave, Grants Pass OR 97526
PH: 541-471-3455 FAX: 541-471-1439

☐ **Name**
Siskiyou Community Health Center (SCHC)
PO Box 1850, Cave Junction OR 97523
PH: 541-592-4111 FAX: 541-592-3916

Person/Agency to ***Receive*** Information: ☐ **Patient/Self**

Name		
Mailing Address		
City	**State**	**Zip**
Phone	**Fax**	

PURPOSE OF THE DISCLOSURE _____ Transfer of Care _____ Coordination of Care _____ Other_____

DATES REQUESTED _____ **All** Dates of Service **OR** Date Range: From _____To _____

TYPE OF COPY REQUESTED ☐ Thumb Drive ☐ Paper ☐ E-mail _____

(For Professional Use only)

INFORMATION REQUESTED (**Must initial each item requested**):

_____ Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

_____ Chart Notes	_____ Specialist Consults	_____ Immunization Records
_____ Lab Results	_____ Hospital Records	_____ Billing Statements
_____ Radiology and Imaging Reports	_____ Physical Therapy Notes	
_____ EKG Reports	_____ Other _____	

SPECIFIC CONSENT (**By initialing the space(s) below, I am specifically authorizing the release of the specified confidential information**):

_____ Records regarding mental illness or developmental disability*	_____ Communicable Disease
_____ Medical Records relating to alcohol and/or drug abuse	_____ Venereal Disease
_____ HIV Test Results	_____ Child Abuse and Neglect
_____ Genetic Testing information and results	_____ Sexual Assault

EFFECTIVE DATE OF AUTHORIZATION

_____ Until the purpose is fulfilled
_____ Other _____

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my health information is disclosed to the recipient, no SCHC staff can guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the health information. I authorize SCHC to use/disclose my health information in the manner described above.

_____

Signature of Patient or Personal Authorized by Law **Date**

_____ _____

***Name and Signature of Witness** *(required for release of information about mental illness or Developmental disability)* **Date**

Staff Initials_____