



AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

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

Address: _____ Type of ID: _____

Healthcare Provider to **Release** Information: _____ Person/Agency to **Receive** Information: Patient/Self

Name Siskiyou Community Health Center (SCHC)		Name	
Mailing Address 1701 NW Hawthorne Ave, Grants Pass OR 97526		Mailing Address	
Phone (541) 471-3455	Fax (541) 471-1439	Phone	Fax

TYPE OF COPY REQUESTED Thumb Drive Paper E-Mail _____
(For Professional Use Only)

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

DATES REQUESTED _____ **ALL** Dates of Service **OR** Date Range: From _____ To _____

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 | _____ Progress Notes | _____ Records related to specific injury |
| _____ Patient History | _____ Billing Records | with following dates: |
| _____ Radiology and Imaging Reports | _____ Specialist Consults | (e.g. Workers Compensation injury) |
| _____ Dental Exam | _____ Diagnosis | _____ |

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, SCHC cannot 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 _____