

**Authorization to Exchange Verbal Health Information**

**Patient Information:** *(Please print)*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Exchange Verbal Information To:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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/Pharmacy | _____ Billing             | _____ Appointment Info.  |

This authorization may be revoked at any time by notifying a Siskiyou Community Health Center staff member. Such notice will be effective immediately upon receipt by Siskiyou Community Health Center records personnel. This consent will be **valid up to one (1) year.**

Date consent begins: \_\_\_\_\_

Date consent expires: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I recognize that the information discussed 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: \_\_\_\_\_