# Siskiyou Community Health Center

## Authorization to Use/Disclose Protected Dental Information

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

Address: _____ City: _____ State: _____ Zip: _____

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

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

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

**Name**

Siskiyou Community Health Center (SCHC)
1701 NW Hawthorne Ave
Grants Pass, OR 97526
P: 541-479-6393 F: 541-479-6489

**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
_____ Patient History
_____ Radiology and Imaging Reports
_____ Dental Exam
_____ Other: _____

_____ Progress Notes
_____ Billing Records
_____ Specialist Consults
_____ Diagnosis

_____ Records related to specific injury with following dates:
(e.g. Workers Compensation Injury)
_____

**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 dental information is disclosed to the recipient, SCHC cannot guarantee that the recipient will not re-disclose the dental 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 dental information. I authorize SCHC to use/disclose my dental information in the manner described above.

_____ _____
**Signature of Patient or Person Authorized by Law** **Date**

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

**Staff Initials:** _____