Siskiyou Community Health Center

Authorization to Use Disclose Information

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

Address: _____ Type of ID: _____

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

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

☐ USB Drive   ☐ Paper   ☐ Email _____

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

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, no SCHC staff can guarantee that the recipient will not re-disclose 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: _____