Siskiyou Community Health Center

Authorization to Receive Protected Health Information

Patient Name | **Date of Birth** | **Phone**

Address | **City** | **State** | **Zip Code**

Healthcare Provider to ***Release*** Information: ❒ **Patient / Self**

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

Person/Agency to ***Receive*** Information:

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

❒ **Name**
Siskiyou Community Health Center (SCHC)
PO Box 1850
Cave Junction, OR 97523
P: 541-592-4111 F: 541-592-3916

Purpose of the Disclosure:
_____ Transfer of Care _____ Coordination of Care _____ Other: _____

Dates Requested:
❒ **Last 3 Years** **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
_____ Lab Results
_____ Radiology and Imaging Reports
_____ EKG Reports
_____ Specialist Consults
_____ Hospital Records
_____ Physical Therapy Notes
_____ Other: _____
_____ Immunization Records
_____ Billing Statements

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*
_____ Medical Records relating to alcohol and/or drug abuse
_____ HIV Test Results
_____ Genetic Testing information and results
_____ Communicable Disease
_____ Venereal Disease
_____ Child Abuse and Neglect
_____ 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, 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 Person Authorized by Law | **Date**

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

Staff Initials _____