

Authorization to Use/Disclose Protected Health Information

Patient Name	Date of Birth	Phone
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Address	Type of ID																
Healthcare Provider to Release Information: <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="border: 1px solid black; padding: 5px;"> Name Siskiyou Community Health Center (SCHC) 1701 NW Hawthorne Ave Grants Pass, OR 97526 P: 541-471-3455 F: 541-471-1439 </td> </tr> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="border: 1px solid black; padding: 5px;"> Name Siskiyou Community Health Center (SCHC) PO Box 1850 Cave Junction, OR 97523 P: 541-592-4111 F: 541-592-3916 </td> </tr> </table>	<input type="checkbox"/>	Name Siskiyou Community Health Center (SCHC) 1701 NW Hawthorne Ave Grants Pass, OR 97526 P: 541-471-3455 F: 541-471-1439	<input type="checkbox"/>	Name Siskiyou Community Health Center (SCHC) PO Box 1850 Cave Junction, OR 97523 P: 541-592-4111 F: 541-592-3916	Person/Agency to Receive Information: <input type="checkbox"/> Patient / Self <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td colspan="3" style="border: 1px solid black; padding: 5px;">Name</td> </tr> <tr> <td colspan="3" style="border: 1px solid black; padding: 5px;">Mailing Address</td> </tr> <tr> <td style="border: 1px solid black; padding: 5px;">City</td> <td style="border: 1px solid black; padding: 5px;">State</td> <td style="border: 1px solid black; padding: 5px;">Zip</td> </tr> <tr> <td colspan="2" style="border: 1px solid black; padding: 5px;">Phone</td> <td style="border: 1px solid black; padding: 5px;">Fax</td> </tr> </table>	Name			Mailing Address			City	State	Zip	Phone		Fax
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City	State	Zip															
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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	_____ Specialist Consults	_____ Immunization Records
_____ Lab Results	_____ Hospital Records	_____ Billing Statements
_____ Radiology and Imaging Reports	_____ Physical Therapy Notes	
_____ EKG Reports	_____ Other: _____	

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*	_____ Communicable Disease
_____ Medical Records relating to alcohol and/or drug abuse	_____ Venereal Disease
_____ HIV Test Results	_____ Child Abuse and Neglect
_____ Genetic Testing information and results	_____ 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, no SCHC staff can guarantee that the recipient will not re-disclose your 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
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*Name and Signature of Witness (required for release of information about mental illness or developmental disability)	Date
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Staff Initials: _____