

## Authorization to Use/Disclose Protected Dental Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Healthcare Provider to **Release** Information:

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

Name		
Mailing Address		
City	State	Zip
Phone	Fax	

Name
Siskiyou Community Health Center (SCHC) 1701 NW Hawthorne Ave Grants Pass, OR 97526 P: 541-479-6393 F: 541-472-4701

**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

<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Records related to specific injury with following dates: (e.g. Workers Compensation Injury)
<input type="checkbox"/> Patient History	<input type="checkbox"/> Billing Records	
<input type="checkbox"/> Radiology and Imaging Reports	<input type="checkbox"/> Specialist Consults	
<input type="checkbox"/> Dental Exam	<input type="checkbox"/> Diagnosis	
<input type="checkbox"/> 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, 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:** \_\_\_\_\_