Siskiyou Community Health Center

Authorization to Use Disclose Information

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

Address: _____ Type of ID: _____

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

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

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

Name		
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
_____ 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, 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: _____