Siskiyou Community Health Center

AUTHORIZATION TO USE/DISCLOSE PROTECTED DENTAL INFORMATION

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

Address: _____ Type of ID:_____

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

Name Siskiyou Community Health Center (SCHC)		**Name**	
Mailing Address 1701 NW Hawthorne Ave, Grants Pass OR 97526		**Mailing Address**	
Phone (541) 471-3455	**Fax** (541) 471-1439	**Phone**	**Fax**

TYPE OF COPY REQUESTED ☐ Thumb Drive ☐ Paper ☐ E-Mail _____
(For Professional Use Only)

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

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

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 your 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_____

Form 1319 5119