Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
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Office Use Only
MRN:
Scanned:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Complete each section, then sign and date

I. Print your full legal name: I, _____ DOB: _____
hereby voluntarily authorize the disclosure of information from my health record.

II. The information disclosed: If records are over 30-pages please mail.

Name of Person/Organization/Facility disclosed by		**Name of Person/Organization/Facility disclosed to**	
Address		Address	
City/State/Zip		City/State/Zip	
Phone	Fax	Phone	Fax

III. The purpose or need for this disclosure is:
☐ Further Medical Care ☐ Attorney
☐ Disability ☐ Insurance ☐ School ☐ Research
☐ 2-Way Release – this allows sharing information between both Person/Organization/Facility listed above
☐ Other (Specify): _____
☐ Personal Use, the first request is at no charge. The charge for additional medical records within 12-months, are $30 for the first 10-pages, $.50 per pages 11-50 and $.25 for each page thereafter. I understand SCHC will supply me these records within 30-days unless I receive notification to extend this timeframe. The format I prefer to receive my record:
☐ I will pick up when ready ☐ Mail to me ☐ Fax to me
☐ Encrypted E-mail at: _____

IV. The information to be disclosed from my health record, check appropriate box(es):
☐ Entire Record, this is 2-years prior from date of this authorization.
☐ Only information related to (specify): _____
_____
☐ Only the period of events from: _____ to: _____

If the information to be disclosed contains sensitive information, additional laws may apply. I understand and agree that this information may be disclosed only if I place my initials in the applicable space(s):

_____ NOT APPLICABLE
_____ Alcohol/Drug Abuse diagnosis & treatment records
_____ HIV/AIDS/STI related information
_____ Mental Health (other than Psychotherapy Notes)
_____ Genetic testing information
_____ Psychotherapy Notes ONLY (By initialing, I am waving any psychotherapist-patient privilege)

V. I understand I may revoke this authorization in writing at any time to the SCHC attention Health Information, except to the extent that action has been taken in reliance on this authorization. I hereby hold harmless and agree to indemnify SCHC employees for any liability arising out of or occurring under this authorization including but not limited to negligence. I understand SCHC will not condition treatment or eligibility for care on my providing this authorization. I understand that my Substance Use Disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR part 2, and the Health Insurance Portability and Accountability Act ("HIPAA"), 45 CFR parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. If this authorization has not been revoked it will expire 365-days from the Date Signed.

Signature of Patient or Personal Representative (state relationship to patient)	*Date Signed*
Signature of Witness if signature is a mark or thumb print	Date signed

Instructions for completing SCHC's Authorization for Use or Disclosure of Protected Health Information form:

I. Print your legal name and date of birth (DOB)

II. Enter the name of the person or organization or facility to where PHI is disclosed

Enter the person's or organization's or facility's mailing address or fax number

Enter the person's or organization's or facility's city, state and zip code

III. Check the box that describes the purpose. Below are brief descriptions

- Further Medical Care – If you are seeking medical attention at another facility, etc
- Attorney – Information will be sent to who you specify in section II. as your attorney
- School – The information will be sent to who you specify in section II. for the purpose of school
- Research – You are requesting information for the purpose of research
- Personal Use – You will receive the requested information to distribute, as you need
- Insurance – You are requesting information to be sent for the purpose of Insurance
- Disability – You are requesting information to be sent for the purpose of Disability
- Research – The information is for research
- 2-Way – This information may be shared between both Persons/Organizations/Facilities to communicate for the purpose you describe in section IV
- Other – You need to specify what it is you want the SCHC to use or disclose

IV. The information you want disclosed from your health record

- Only information related to – specify diagnosis, injury, operations, special therapies, etc.
- Only the period of events from, to – you need to specify the date range for example 01/01/2018 to 03/30/2018
- Other – you need to specify such as PRC, billing, employee health, etc
- Entire Record – We go back 2-years
- In order to release sensitive information regarding HIV/AIDS, Sexually Transmitted Infections (STI), Alcohol/Drug Abuse, and/or Mental Health (not Psychotherapy notes), you MUST initial the appropriate spaces
- Psychotherapy Notes Only – in order to authorize the use or disclosure of psychotherapy notes, you initial this space only. This is because authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to psychotherapy notes.

V. You read the statement, acknowledge then

- If you do not agree, this release is not valid and no information will be used or disclosed
- If you agree, you enter the expiration date up to 365-days from the date you are signing this form
- Protected Health Information form
- Sign or mark or if you have a legal representative who is able to sign on your behalf they would sign and state their relationship to you
- Date for today
- If your signature is a mark, the witness needs to sign here