

The Confederated Tribes of the Grand Ronde Community  
Health & Wellness Center  
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

**I authorize:**

\_\_\_\_\_ to disclose PHI to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose for requesting information (please circle):** Legal Insurance Personal Continuation of Care  
Other (please specify other on line below):  
\_\_\_\_\_

**I authorize the following PHI to be released from my medical record (initial all that apply):**

- Entire medical record (all information)  
 Summary of Care (Includes medication list, allergy list, problem list, immunizations, diagnosis list, test results, vital signs, smoking status, and demographic information)  
 Medical Chart Notes  
 Dental Chart Notes  
 Optometry Chart Notes  
 Test Result(s)  
 Radiology imaging studies/reports  
 Other (describe): \_\_\_\_\_

**Covering the period of healthcare from:** Specific Date(s): \_\_\_\_\_ to \_\_\_\_\_ **OR**  
All past, present and future encounters/visits

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

**State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained by initialing next to the item:**

- Alcohol, Drug, or Substance Abuse Records  
 HIV Testing/Results  
 Mental Health

**Disclosure Format (paper is default if none circled):** paper format electronic format (CD-only available on records contained exclusively within the electronic health record—not applicable to paper records)

**By signing this authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Health Information Management at the following address: PO Box 97, Grand Ronde, OR 97347. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: \_\_\_\_\_. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Patient or Authorized Representative Signature Date

\_\_\_\_\_  
Print Name (if authorized representative) Relationship to patient (if authorized representative)