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 (check 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)