Siletz Community Health Clinic

Authorization to Discuss Medical Information with Family, Friends & Caregivers

Patient Name____ Date of Birth__________________

THIS IS NOT A RELEASE OF INFORMATION (ROI). The Siletz Community Health Clinic is providing this form (optional) for you to allow family, friend, and caregivers to receive medical information you would like them to gather if you are unavailable or just want them to be a part of your care team. By completing this form, a Release of Information is not required.

Please initial each box below that you give authorization for:

INITIAL all boxes below that apply: **if box is not initialed** information will not be released.

	Appointment Date/Times – Medical & Dental		HIV/AIDS Status (testing and results)
	Lab, Diagnosis, Treatment Plans – Medical & Dental		Drugs/Alcohol (Status/History/Treatment Plans)
	Billing – Including services provided		Behavioral Health (Status/History/Treatment Plans)
	Transportation Needs		STI Screening – Results and Treatment Plan
	Pregnancy Testing, Prenatal Care, Birth Control, and Family Planning		Pharmacy (Refills/Discussion/Pick Up)

Is it ok to leave a detailed voicemail? ❑ Yes ❑ No If yes, please list number______________________

Is it ok to leave a detailed voicemail to individuals listed below? ❑ Yes ❑ No

Limit voicemail to only information specified____

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Information to be given to: (Attach additional sheets if needed)

1. Name______________________________________ Phone______________________

   Relationship__________________________________
2. Name______________________________________ Phone______________________

   Relationship__________________________________

I understand that:

- This authorization is valid until revocation by me. I understand I have the right to revoke my permission, in whole or in part, at any time except where SCHC has already made disclosures in reliance upon this request. I understand I must notify SCHC in writing if I wish to revoke any part of my permission. I understand I can request a copy of this signed form at any time.
- A photocopy or fax of this form is the same as the original.
- This authorization is giving the SCHC the right to discuss my medical information with the one or more people listed above and the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- This consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.

Signature_______________________________________ Date______________________

*(16 or older **must sign**. Parent/guardian to sign for patients under age 16)*

Printed Name____________________________________

Relationship to patient (if signed by person other than patient)__________________________