Exhibit C
Guam Community Health Centers
(Northern and Southern Region Community Health Centers)

Patient Authorization For The Guam Community Health Centers To Release Protected Health Information

By signing this authorization, I authorize the Guam Community Health Centers to use and/or disclose certain protected health information (PHI) about me to the party or parties listed below.

This authorization permits the Guam Community Health Centers to use or disclose to ____
Person or Entity to Receive the information

the following health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc). ____

____

____

This authorization will expire on ______________________.
(Expiration Date or Defined Event)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Guam Community Health Centers have acted in reliance upon this authorization. My written revocation must be submitted to the Guam Community Health Centers' Privacy Officer, **Dr. William Weare, Privacy Officer, 162 Abman Drive, Inarajan, Guam 96917.**

Signed by: ______________________________ ____________________
(Signature of Patient or Legal Guardian) **Relation to Patient**

Print Name of Patient or Legal Guardian **Date:** ____________