Authorization for Use or Disclosure of Protected Health Information

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Please complete entire form. Incomplete authorizations will not be processed and will be returned for completion.

Name of Patient _____

Date of Birth _____ Health Record Number _____

Daytime Phone # _____ Evening Phone # _____

Address _____

City, State, Zip Code _____

INFORMATION TO BE DISCLOSED TO

Name _____

Daytime Phone # _____ Fax _____

Address _____

City, State, Zip Code _____

Email (Please print clearly) _____

INFORMATION TO BE DISCLOSED TO:

CD (.pdf) ☐ Paper ☐ Email ☐

INFORMATION TO BE RELEASED

From & To Dates _____

☐ History/ Physical _____

☐ Lab Report(s) _____

☐ Radiology Report(s) _____

☐ Consultation(s) _____

☐ Emergency/ Urgent Care Records _____

☐ Operative Report(s) _____

☐ Other _____

I understand that this health information may include HIV/AIDS information and/or information relating to diagnosis or treatment of psychiatric disabilities or substance abuse and/or genetic testing, and that by initialing below, I am specifically authorizing the release of information relating to:

☐ Drug/alcohol diagnosis, treatment or referral

☐ Mental Health ☐ HIV/AIDS ☐ Genetic Testing

PURPOSE OF DISCLOSURE

☐ Continuing care ☐ Personal records ☐ Legal ☐ Insurance ☐ On site review

☐ Other _____

1. I understand that the information used or disclosed as stated in this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. However, I also understand that federal or state law may restrict re- disclosure of drug/alcohol diagnosis, treatment or referral, HIV/AIDS-related, and psychiatric/mental health information.

2. I understand that Salem Health will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

3. This authorization will expire (insert date or event):

_____

or 6 months from the date of this authorization. A photocopy of this form will be considered as valid as the original.

4. I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, at 890 Oak Street SE, Salem, OR 97301.

This authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

5. A copy of this signed form will be provided to the patient or authorized person.

6. If you are requesting that your information be sent to you or another person by email, you further acknowledge and agree to the risks of transmitting and receiving your information by email, and you agree to release and hold harmless Salem Health Hospitals and Clinics and its related and affiliated entities from any liability that may result from using e-mail to communicate with you or another person you may have designated to receive emails that include your Health Information. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using e-mail (except as required by law).

By signing below, I acknowledge that I have read and understand this authorization, and agree to such disclosure.

_____ _____ **OR** _____ _____

Signature of Patients Date Parent/Legal Guardian/Authorized Person Date

_____ _____ _____

Records Received By Date Relationship to Patient

☐ **Salem Hospital**
890 Oak Street SE
Salem, OR 97301
503-561-5750

☐ **West Valley Hospital**
525 SE Washington St.
Dallas, OR 97338
503-623-7309

☐ **Clinic:** _____
Address: _____
_____
_____

☐ ID verified by _____
☐ Call for pickup
☐ Mail records
☐ Email Verified

DSC 422355 (9/16)