AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Salem Clinic
Belong. For life.

Patient Name _____

Birth Date _____ Social Security # (Last 4 Digits) _____

Current Address _____

Daytime Phone # _____ Cell # _____

REASON FOR REQUEST

- ☐ Personal
- ☐ Medical Care
- ☐ Benefits
- ☐ Workers' Compensation
- ☐ Permanent Transfer to a New Provider
- ☐ Other

_____

I AUTHORIZE INFORMATION RELEASE ***FROM:***

Note: If addresses are not provided, it may cause a delay in your request.

_____
Name of Facility/Provider Sending Information

_____
Address of Facility/Provider

_____
City, State, and Zip Code

INFORMATION TO BE RELEASED ***TO:***

_____
Name of Facility/Provider Receiving Information

_____
Address of Facility/Provider

_____
City, State, and Zip Code

_____ _____
Phone # Fax #

Type of Information to be Released

- ☐ Chart Notes
- ☐ Laboratory Results
- ☐ X-Ray Reports only**
- ☐ Immunization Records
- ☐ Medication Records
- ☐ Physical Therapy
- ☐ Other: _____

** For film requests, call 503-399-2484, option 3.

☐ **Most Recent Visit** ☐ **Medical Records from** _____ **to** _____ ☐ **Last 2 years**

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV / AIDS information
Initials

_____ Mental health information
Initials

_____ Drug / Alcohol diagnosis, treatment or referral information
Initials

_____ Genetic testing information
Initials

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your healthcare or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research. You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Privacy Officer at 2020 Capitol Street NE, Salem Oregon 97301, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization and state that you are revoking the Authorization. This Authorization will expire on the earlier of (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DATE

_____ _____
PRINT PATIENT'S NAME or NAME OF PATIENT'S LEGAL REPRESENTATIVE RELATIONSHIP to PATIENT