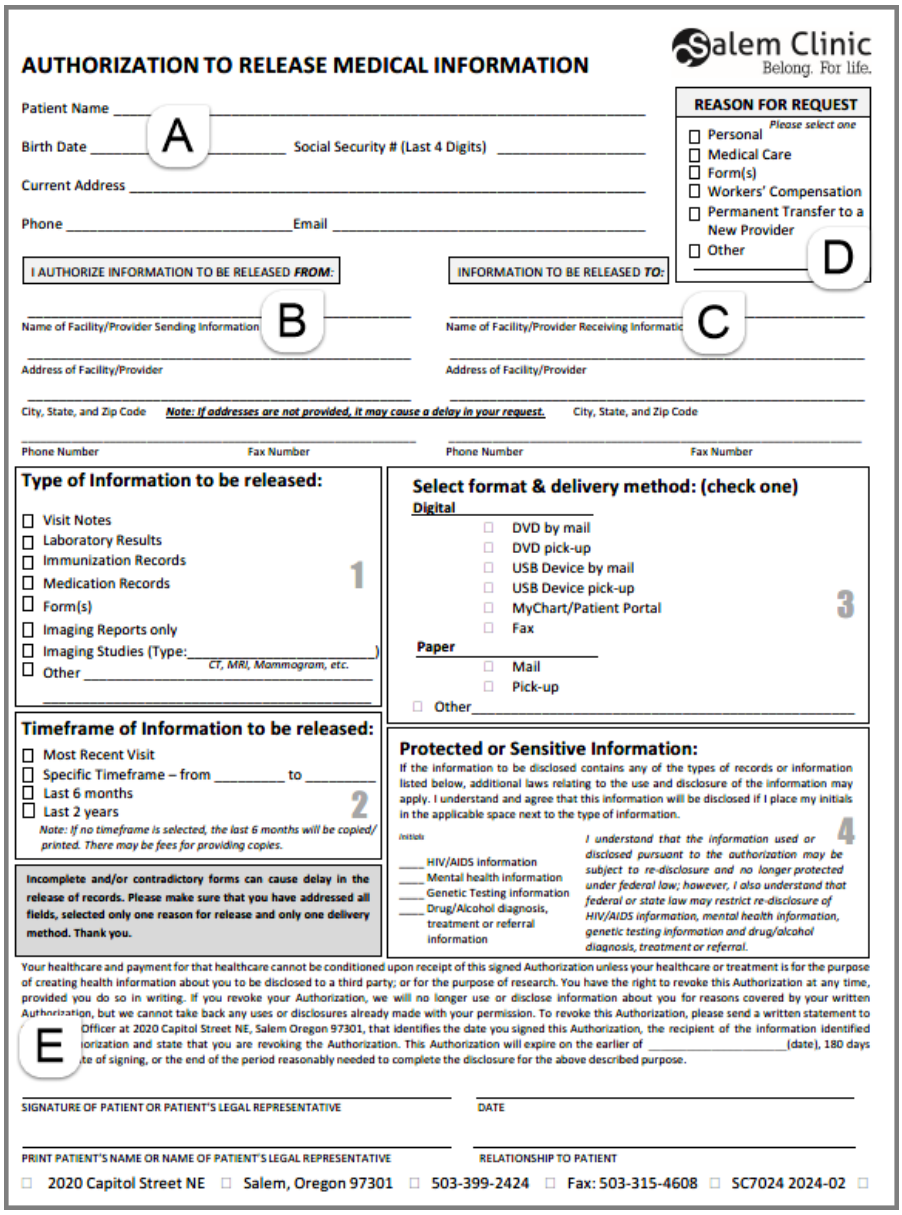
How to Complete an Authorization to Release Medical Information Form

Completing an **Authorization to Release Medical Information** form, more commonly known as an ROI, is a detailed process. Incomplete and/or contradictory forms can cause delays in the release of records. If this guide does not answer your questions regarding the ROI form, our Health Information Management team is available to help you; we can be reached at 503-375-7407 during normal business hours.



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Salem Clinic
Belong. For life.

Patient Name _____

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

Current Address _____

Phone _____ Email _____

REASON FOR REQUEST *Please select one*

- ☐ Personal
- ☐ Medical Care
- ☐ Form(s)
- ☐ Workers' Compensation
- ☐ Permanent Transfer to a New Provider
- ☐ Other _____ D

I AUTHORIZE INFORMATION TO BE RELEASED *FROM*:

Name of Facility/Provider Sending Information B

Address of Facility/Provider

City, State, and Zip Code

Phone Number Fax Number

INFORMATION TO BE RELEASED *TO*:

Name of Facility/Provider Receiving Informatic C

Address of Facility/Provider

City, State, and Zip Code

Phone Number Fax Number

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

Type of Information to be released: 1

- ☐ Visit Notes
- ☐ Laboratory Results
- ☐ Immunization Records
- ☐ Medication Records
- ☐ Form(s)
- ☐ Imaging Reports only
- ☐ Imaging Studies (Type: _____) *CT, MRI, Mammogram, etc.*
- ☐ Other _____

Timeframe of Information to be released: 2

- ☐ Most Recent Visit
- ☐ Specific Timeframe – from _____ to _____
- ☐ Last 6 months
- ☐ Last 2 years

Note: If no timeframe is selected, the last 6 months will be copied/ printed. There may be fees for providing copies.

Incomplete and/or contradictory forms can cause delay in the release of records. Please make sure that you have addressed all fields, selected only one reason for release and only one delivery method. Thank you.

Select format & delivery method: (check one) 3

Digital

- ☐ DVD by mail
- ☐ DVD pick-up
- ☐ USB Device by mail
- ☐ USB Device pick-up
- ☐ MyChart/Patient Portal
- ☐ Fax

Paper

- ☐ Mail
- ☐ Pick-up
- ☐ Other _____

Protected or Sensitive Information: 4

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.

Initials

- ____ HIV/AIDS information
- ____ Mental health information
- ____ Genetic Testing information
- ____ Drug/Alcohol diagnosis, treatment or referral information

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.

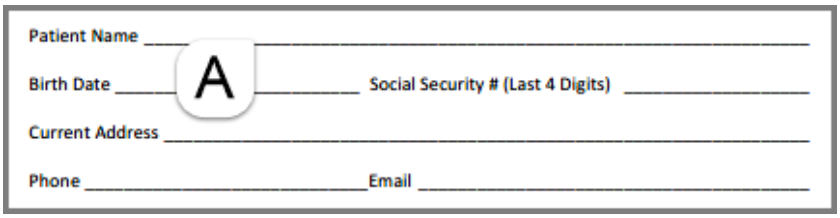
Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your healthcare or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research. You have the right to revoke 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 E Officer at 2020 Capitol Street NE, Salem Oregon 97301, that identifies the date you signed this Authorization, the recipient of the information identified orization and state that you are revoking the Authorization. This Authorization will expire on the earlier of _____(date), 180 days te 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

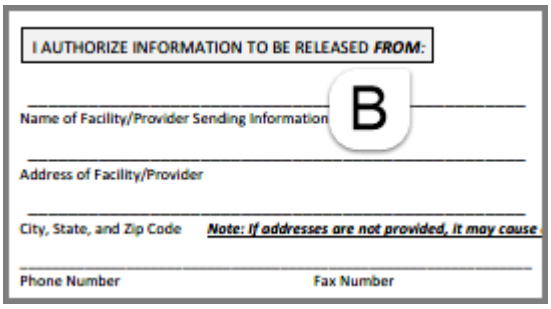
☐ 2020 Capitol Street NE ☐ Salem, Oregon 97301 ☐ 503-399-2424 ☐ Fax: 503-315-4608 ☐ SC7024 2024-02 ☐

A – Patient Demographics



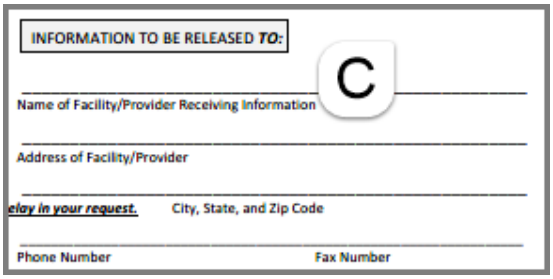
- The information entered in this section should identify who the patient is – who's information needs to be released. That is not always the same person that is filling out the ROI form.
- Handwriting needs to be legible.
- The more information you can provide here, the better.
- Note: If the patient's name has changed since the last time they were seen, please provide both the previous name and the current name along with a copy of government issued ID.

B – From Section



- This area identifies where the patient records currently are located – who you are asking to release/share the records.
    - If you want previous records sent to Salem Clinic from another doctor's office, the other doctor's office information belongs here.
    - If you want Salem Clinic to send the records somewhere, enter Salem Clinic's information here.
- Enter as much information as you have available; if there is insufficient information to correctly identify the doctor's office/hospital, then we will be unable to process the request.

C – To Section



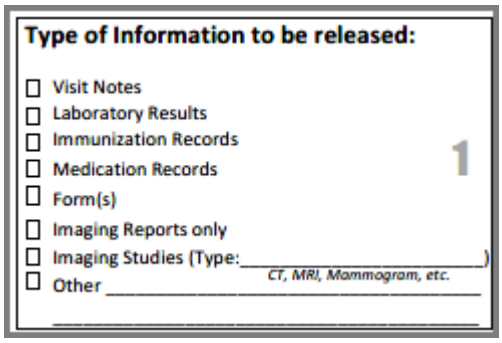
- This area identifies where the patient records will be released to – who will receive the records.
    - If you want previous records sent to Salem Clinic from another doctor's office, enter Salem Clinic's information here.
    - If you want Salem Clinic to send the records somewhere, enter the other doctor's office/location's information here.
- Enter as much information as you have available; if there is insufficient information to correctly identify the doctor's office/hospital, then we will be unable to process the request.

D – Reason for Request

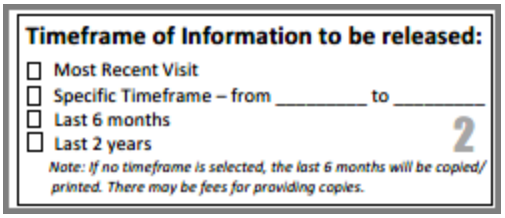
- Select only one reason for the request, but always select one. Many offices will not release records if this area is left blank.
- If you don't see the reason you want to request the records, use the Other option and write in your reason for the request.

1 – Type of Information

- Check next to the types of records you want to have shared. You can make more than one selection.
- If you do not see an option that you want, use the Other option and write in what records you want to have released.



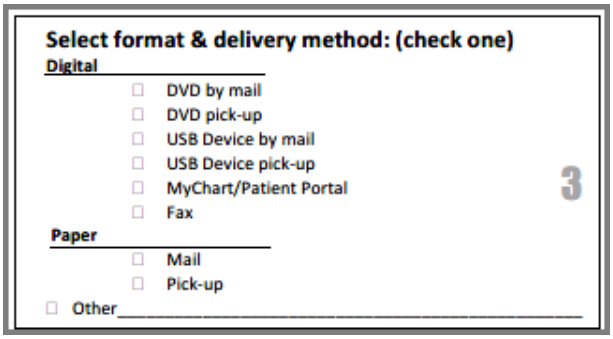
2 – Timeframe



- Check next to the timeframe for the records you want to have released.
- If you want to have all of your records released, write ALL in the Specific Timeframe option.
- If you do not make a selection in box 2, your release will be processed for the last 6 months of records.

3 – Format & Delivery

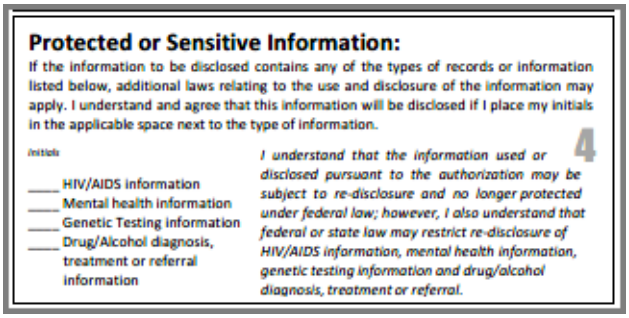
- Select only one format and delivery option.
- If you don't see the format and delivery option you want, use the other option and write in how you would like to have your records delivered. If your request is feasible, we will make every attempt to provide records in the format and via the delivery method requested.



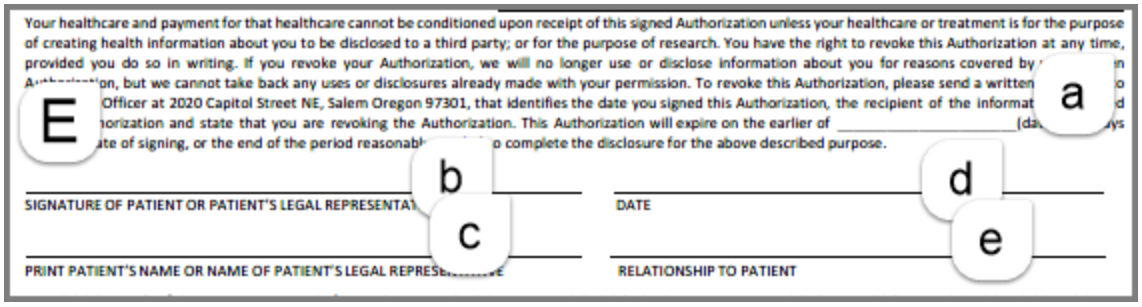
- If you do not make a selection in box 3, your release will be printed and mailed.

4 – Protected or Sensitive Information

- Some information that is sensitive in nature is more protected under state and federal law.
- If you want to have sensitive or protected information released, you must initial next to the type(s) of information you are authorizing the release of.
- This box is optional – you are not required to release sensitive information.



E – Signatures and Dates



a. This field does NOT need to be filled in. Salem Clinic ROIs are automatically good for 180 days. This field allows you to shorten or lengthen how long the ROI is good for. If you do not have a reason to shorten or lengthen the timeframe the release is good for, it is best to leave this field blank.
b. Only the patient or the legal representative of the patient can sign here. For legal representatives, we do need paperwork on file to prove the legal status, as well as identification to match a signature to.
c. This field should contain the printed name of the person who signed the ROI form.
d. This field should contain the date the ROI form was signed.
e. This field should contain the relationship of the person who signed the form to the patient. If you signed a form for yourself, please write self in this field.

Miscellaneous Information

What parts of the ROI form are required?

- Sections A, B, C, D, 1 and E are all required to be completed in order for the ROI form to be processed.
- We encourage you to complete sections 2 and 3, but do have defaults in place if they are left blank.
- Section 4 is optional – at the discretion of the patient.

There may be fees for providing copies of records; if you are responsible for charges, you will have to pay the fees prior to having the records released.