

Place patient label here (optional)



PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

IMPORTANT NOTICE: The law prohibits release of confidential medical information without the written, voluntary consent of the undersigned patient.

Print Patient Name: _____

Date of Birth: _____

PHONE MESSAGES

Initial or check

I authorize Salem Clinic to leave a detailed voice mail message on my listed phone number (cell home)

SHARE INFORMATION

Initial or check
OR

I do not want my information given to anyone other than myself.

Initial or check
and list person(s)
approved below

I authorize Salem Clinic to discuss information regarding my appointments and my medical conditions, including results, printing and release of med lists (within 30 days of patient's appointment) with the following person(s):

Name

Relationship

Name

Relationship

This authorization can be revoked or updated at any time by the patient in writing or by updating and signing this form.

REVOKE INFORMATION SHARING

Initial or check and
list person(s) you are
revoking below

I want to revoke permission to share my information from the following person(s):

Name

Relationship

Name

Relationship

I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Attach copy of photo ID, with signature of patient or legal representative, if not verified with staff at time of signing.

Signature of Patient

Today's Date

Signature of Legal Representative of Patient

Today's Date

Printed Name of Legal Representative of Patient

Today's Date