Place patient label here (optional)

Salem Clinic
Belong. For life.

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:_____

_____**I authorize Salem Clinic to discuss information regarding my appointments, my medical conditions, including results, printing and release of med lists (within 30 days of patient's appointment) and to leave phone messages on my listed phone number (☐ Cell ☐ Home) voicemail and/or with any of the following people:**

Initial or check and list persons approved below

(Check applicable)

OR

_____**I do not want any information given to anyone other than myself, or I want to revoke permission**

Initial or check and list persons you are revoking below

_____	_____
Name	Relationship
_____	_____
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.

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 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