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.

First Name	Middle Name	Last Name	
Date of Birth	Maiden/Previous/Alias/Other Names		
Address	City	State	Zip
Phone Number	E-mail Address		

PURPOSE OF DISCLOSURE

☐ Continuing Care	☐ Personal Records	☐ Legal	☐ Insurance
☐ Transfer of Care	☐ School	☐ Other	

INFORMATION DISCLOSURE

Health Records to be released **FROM**

- ☐ Salem Hospital
- ☐ West Valley Hospital
- ☐ Santiam Hospital
- ☐ Pharmacy
- ☐ Salem Health Medical Clinic
- ☐ Salem Health Specialty Clinic
- ☐ Santiam Clinic

☐ Other: Hospital/Clinic Name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Health Records to be **SENT TO**

- ☐ Self
- ☐ Salem Health Hospitals & Clinics
- ☐ Other: Name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

How to send:

- ☐ E-mail
- ☐ Mail:
  - ☐ CD
  - ☐ Paper
- ☐ MyChart
- ☐ Fax

INFORMATION TO BE RELEASED

Services	Date Range
☐ Billing Records	☐ Last Visit
☐ Clinic/Office Notes	☐ 30 Days
☐ History/Physical	☐ 60 Days
☐ Imaging	☐ 6 Months
☐ Immunization Records	☐ 1 Year
☐ Lab/Pathology Reports	☐ 2 Years
☐ Operative Reports	☐ 5 Years
☐ Radiology Reports	☐ 10 Years
☐ Rehab Records	☐ From_____to_____
☐ Other *(specify)*:_____ _____	

Note: *Imaging and Billing requests may be processed and mailed separately.*

AUTHORIZATION/SIGNATURE

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. By initialing below, I authorize the release of this information.

Initials	HIV/AIDS	Initials	Mental Health	Initials	Drug/Alcohol	Initials	Genetic Testing

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 12 months from the date this form was signed, or on the following date: _____
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 if requested.
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.

Signature of Patient or Patient Healthcare Representative	Printed Name	Relationship to Patient	Date

Mail Completed/Signed Form To:
Salem Health HIM
890 Oak Street SE
Salem, OR 97301

OR

Fax/Email Completed/Signed Form To:
Fax: 503-814-2728
Email: MedicalRecords@salemhealth.org

Questions? Call 503-561-5750

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

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