

SALEM REHABILITATION ASSOCIATES, INC

P.O. Box 845
Salem, OR 97308
(503) 561-5976 phone
(503) 561-4912 fax

John A. French, MD
J. David Hook, MD

Erik Blake, MD
Raymond Brumbaugh, MD
Steve X Truong, MD

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION:

Name _____ Date of Birth _____

Address _____

Social Security # _____ Telephone () _____

PERSON AUTHORIZED TO RECEIVE INFO:

Name _____

Address _____

Phone () _____

DATES OF HEALTH CARE TO BE RELEASED:

From (date) _____

To (date) _____

PERSON AUTHORIZED TO RELEASE PHI:

PURPOSE OF REQUEST:

Treatment or consultation At the request of patient Billing or claim Other _____

TYPE OF INFORMATION TO RE RELEASED:

History & Physical

Consultation

Follow up reports

Discharge Summary

EMO/NCV Report

Ledger/Billing

Other _____

Time limit and right to revoke authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time teen revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Salem Rehab Associates, Inc. Unless revoked, this authorization will expire in 180 days or on the following date or event: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand that if my medical or billing record contains information In reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree lo its release

yes no _____ initials

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protested by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or personal representative who may request disclosure:

I understand that Salem Rehab Assoc Inc may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Salem Rehab, Assoc. Inc to use/disclose the protected health information specified above.**

Signature _____ Date _____

Relationship if not the patient _____ Verification of identity (initials) _____