SALEM REHABILITATION ASSOCIATES, INC

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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 Abase, 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)**_____