SALEM REHABILITATION ASSOCIATES, INC.
3624 River Rd N.
Keizer, OR 97303
Phone 503.561.5976 Fax 503.561.4912

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____

Address: _____ Phone: _____

I hereby authorize:

_____
(name of person, facility, agency)

_____
(address)

_____
(city, state, zip)

To provide medical information to:

_____
(name of person, facility, agency)

_____
(address)

_____
(city, state, zip)

This authorization is limited to the following treatment and/or time period _____

PURPOSE OF REQUEST:

☐ Treatment or consultation ☐ At the request of patient ☐ Billing or claim ☐ Other_____

TYPE OF INFORMATION TO BE RELEASED:

☐ Consult/Chart notes ☐ EMG/NCV Report ☐ Imaging ☐ Lab Reports ☐ Other _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this INFORMATION WILL BE DISCLOSED IF I PLACE MY INITIALS IN THE APPLICABLE SPACE NEXT TO THE TYPE OF INFORMATION.**

_____ HIV/AIDS information _____ Drug/alcohol diagnosis, treatment, or referral information
_____ Mental health information _____ Genetic testing information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to our office and state you are revoking your authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information, specifically require my authorization prior to redisclosure. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

_____

SIGNATURE of Patient or Patient's Legal Representative **Date**

_____

Print patient's name or name of Patient's Legal Representative **Relationship to Patient**

Staff Initials:_____ Call Pt. _____ Mail _____ Patient Portal _____ Other _____