Salem Hospital
West Valley Hospital
A part of Salem Health

☐ Salem Hospital
890 Oak Street SE
Salem, OR 97301
(503) 561-5750

☐ West Valley Hospital
525 SE Washington St.
Dallas, OR 97338
(503) 623-7309

☐ Clinic: _____
Address: _____
_____
_____

Authorization for Use or Disclosure of Protected Health Information

Please complete entire form. Incomplete authorizations will not be processed and will be returned for completion.

Name of Patient _____

Date of Birth _____ Health Record Number _____

Daytime Phone # _____ Evening Phone # _____

Address _____

City, State, Zip Code _____

Information to be disclosed to:

Name _____

Daytime Phone # _____ Fax # _____

Address _____

City, State, Zip Code _____

Information to be released:

From & To Dates _____

- ☐ History/ Physical _____
- ☐ Lab Report(s)_____
- ☐ Radiology Report(s)_____
- ☐ Consultation(s)_____
- ☐ Emergency/ Urgent Care Records_____
- ☐ Operative Report(s) _____
- ☐ Other_____

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, and that by initialing below, I am specifically authorizing the release of information relating to:

- ☐ _____ Drug/alcohol diagnosis, treatment or referral
- ☐ _____ Mental Health
- ☐ _____ HIV/AIDS
- ☐ _____ Genetic Testing

Purpose of Disclosure:

☐ Continuing care ☐ Personal records ☐ Legal ☐ Insurance ☐ On site review ☐ Other _____

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 (insert date or event): _____, or 6 months from the date of this authorization. A photocopy of this form will be considered as valid as the original.
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.

By signing below, I acknowledge that I have read and understand this authorization, and agree to such disclosure.

_____ _____ OR _____ _____

Signature of Patient | Date | Parent/ Legal Guardian/ Authorized Person | Date

_____ _____ _____

Records Received By | Date | Relationship to Patient

☐ ID verified by _____ ☐ Call for pickup ☐ Mail records