Salem Health
Hospitals & Clinics

Salem Bariatric Surgery Center
875 Oak Street SE, Bldg C Suite #5040
Salem, OR 97301
Phone: 503-814-5286 Fax: 503-814-5469

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 (Please Print) _____

Date of Birth _____ Phone _____

Address _____

City, State, Zip Code _____

I hereby authorize the following provider _____ to disclose my protected health information to the Salem Bariatric Surgery Center for the purpose of evaluation and continuing care.

Provider Name _____

Provider Address_____

Phone Number _____ Fax Number _____

INFORMATION TO BE RELEASED:

From & To Dates ___January 2016 to Present_____

☐ Consultation(s) _____

☐ History/Physical _____

☐ Lab Report(s)_____

☐ Radiology Film(s)_____

☐ Operative Report(s) _____

☐ Radiology Report(s) _____

☐ Emergency/Urgent Care Records _____

☐ 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

☐ HIV/AIDS

☐ Mental Health

☐ 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 my 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 12 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