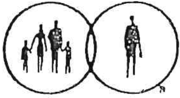

WEST SALEM FAMILY PRACTICE ASSOCIATES, LLC

1275 Wallace Road N.W. • Salem, Oregon 97304 • (503) 371-3232 • Fax (503) 375-2398

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Full Name______________________________ Date of Birth ______________________________

Street Address ______________________________ Social Security # (Last 4 digits) ____________________

City, State, Zip Code______________________________ Phone/Cell Number __________________________

Release Health Information from:	Release Health Information to:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
Phone/Fax ________________________	Phone/Fax ________________________

I consent to have all information faxed from/to the above facility/clinic. ____Yes ___No Transfer of care ____Yes ____No

Which Information do you wish to have released? Dates of Service: From_______________ To__________________

___3 years of chart notes	___All Cardiology reports/testing
___3 years of Laboratory	___All Pulmonary reports/testing
___All Pathology	___All Ophthalmology reports/testing
___All Radiology	___All Operative reports/discharge summaries

The following PHI <u>will not</u> be released or copied unless you indicate by initialing:

___ AIDS/HIV (Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus)

___Mental Health (Psychiatric Care and/or Psychological Assessments)

___Treatment for Alcohol and/or Drug Abuse

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for __________ months from the date of signature.

I understand that I may cancel this request at any time with written notification but that it will not affect any information release prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulation. I understand and accept the statements contained in the authorization.

____ ____________________

Signature of individual (or guardian or Person Representative of patient's estate) Date

Copy charges may be assessed in accordance with Oregon State Law.