Salem Naturopathic Clinic, P.C.
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

REASON FOR REQUEST:
*Please Select One

- Personal
- Permanent Transfer to a New Provider
- Coordination of Care
- Other: ____________________

Patient Name: ____________________________________ **Date of Birth:** ___________________

Current Address: ____

Email: ____

Phone: ____

I AUTHORIZE INFORMATION TO BE RELEASED **FROM**:		INFORMATION TO BE RELEASED **TO**:	
Name of Facility/Provider Sending Information:		Name of Facility/Provider Receiving Information:	
Address of Facility/Provider:		Address of Facility/Provider:	
City, State, and ZIP code:		City, State, and ZIP code:	
Phone:	Fax:	Phone:	Fax:

TYPE OF INFORMATION TO BE RELEASED:		TIMEFRAME OF INFORMATION TO BE RELEASED:	SELECT FORMAT & DELIVERY METHOD
All Healthcare Information; OR	Admin Forms	Most Recent Visit	Fax
Visit Notes	Imaging Reports Only	Specific Timeframe: ______ to ______	Pick-Up
Laboratory Results	Other _______________	Last 6 Months	Verbal
Medication Records	_______________________	Last 2 Years	Other ____________

PROTECTED OR SENSITIVE INFORMATION:
*Initial on lines provided

____HIV/AIDS information

____Mental Health information

____Genetic Testing information

____Drug/Alcohol diagnosis, treatment, or referral information

If the information to be disclosed contains any of the types of record or information listed to the left, additional laws relating to 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.

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral records.

You have the right to revoke this authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for reasons covered by your written authorization, but we cannot take back any uses or disclosure already made with your permission. To revoke this authorization, please send a written statement to Medical Records at 1305 Broadway St NE, Salem OR 97301, that identifies the date you signed this authorization, the recipient of the information identified in this authorization and state that you are revoking the authorization.This authorization will expire on the earlier of _______________ (Date), 180 days from the date of signing, or the end of the period reasonably needed to complete disclosure for the above described purpose.

By signing this form I request and authorize the release of my confidential health information to the clinic/physician listed above.

_______________________________________ _______________________________________
SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE: DATE:

_______________________________________ _______________________________________
PRINT PATIENT'S NAME OR NAME OF PATIENT'S LEGAL REPRESENTATIVE: RELATIONSHIP TO PATIENT: