



REGIONAL HEALTH SERVICES

Salem Hospital Bariatric Surgery Center

P.O. Box 14001

665 Winter Street SE Salem, Oregon 97309-5014

(503)561-5286 FAX (503) 561-4866

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Identification Verified
If picked up in person:
Picture ID
DL#

Patient's Name:
Date of Birth: Soc. Sec. #:
Patient Phone #:
Medical Record #:
Date(s) of Service:

1. I authorize the use of the above named individual's health information as described below.

2. I hereby authorize:

(Fill in name of individual/facility/agency)
(Fill in Address)
(City, state, zip code)

3. To provide medical and /or psychiatric information to:

(Fill in name of individual/facility/agency)
(Fill in Address)
(City, state, zip code)

4. Indicate the information and time period that is to be disclosed: Time period: to

History/Physical Operative Report(s) Emergency and Urgent Care Record(s)
Lab Report(s) Radiology Report(s) Pathology
Consultation(s) Radiology Film(s) Diagnostic Test(s)
Discharge Summary

Other

5. 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 only if I place my initials in the applicable space to the type of information.

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

6. This information for which I am authorizing disclosure will be used for the following purpose:

Personal Records Patient care On site review Legal Other (please describe)

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OVER

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
8. This authorization will expire (insert date or event)\*: \_\_\_\_\_  
 \*If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand that I will receive a copy of this signed authorization.
11. I understand that authorizing the use or disclosure of the information identified above is voluntary. Salem Hospital will not condition treatment, payment, enrollment or benefits on whether I sign this authorization.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Note: Incomplete Authorizations will not be processed and will be returned to you for completion.

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