

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

To: **Salem Psychiatric Associates, P.C.**
 821 Saginaw St. S.
 Salem, Or 97302
 Phone: (503) 362-1999
 Fax: (503) 362-9671

Attention: _____ Edward F. Daly, M.D.
 _____ Rebecca L. Ricoy, M.D.
 _____ Steven C. Tackett-Nelson, M.D.
 _____ Janice C. Veenhuizen, M. D.
 _____ Sandra Bassett, PMHNP

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize:

 (Name of care provider/hospital)

 (Address, telephone and/or fax number)

To Release _____ information to Salem Psychiatric Associates, P.C.
 To Release _____ information from Salem Psychiatric Associates, P.C.
 To Exchange _____ information with Salem Psychiatric Associates, P.C.

******If these records do not exist, please contact our office.******

This information will be used on behalf of: _____
 (Full name of patient)

Date of Birth: _____ / _____ / _____ Address: _____

By initialing the below, I specifically authorize the release of medical records indicated.

Clinician office chart notes
 Transcribed hospital records
 Laboratory reports
 _____ Specific records needed for continuity of care: _____

If the information you are requesting includes specially protected information such as HIV, substance abuse, mental health, and genetic testing information, the information listed below must be initialed to be included with other documents.

Mental health information
 HIV/AIDS related records
 Genetic testing information

Drug/Alcohol diagnosis, treatment or referral: *(Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information below.)*

_____ This authorization is limited to the following time period: _____
 _____ This authorization is limited to the following treatment: _____
 _____ This authorization is limited to a worker's compensation claim for injuries of: _____

Authorization to release of my records via FAX and/or via PHONE

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 (6 mos) from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature

Date Signed

Renewal Date

