SALEM REGIONAL MEDICAL CENTER
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization allows the Salem Regional Medical Center (SRMC) to disclose confidential health information about you. The Authorization may be revoked. It will remain in effect for sixty (60) days unless a different time is stated. You are entitled to a copy of the completed authorization. **There may be fees charged for any copying associated with this request.** If you are a person with a disability and you require this authorization in an alternative format or require a special accommodation to complete this form, you may request assistance from SRMC staff or from the SRMC Chief Privacy Officer.

PATIENT		
	Patient Name (First, Middle, Last) *(Please print)*	Date of Birth (mm/dd/yyyy)
	Patient Address (Street or P.O. Box, City, State, Zip Code)	
	Phone Number:	

1. I authorize the use or disclosure of the health information as described below.
2. I understand that any information disclosed may include information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse and information obtained by the Salem Regional Medical Center from other Hospitals and providers.

4. Dates of service:_____

5. The type and amount of information to be disclosed is as follows:
   a. ❒ Emergency Dept Record from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   b. ❒ Immunization Record from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   c. ❒ History & Physical from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   d. ❒ Psychiatric Care Information from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   e. ❒ HIV/AIDS Information from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   f. ❒ Discharge Summary from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   g. ❒Laboratory Results from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   h. ❒ X-Ray and Imaging Reports from (date) __/__/__ to (date) __/__/__ *or* ❒ Most Recent Only
   i. ❒ Consultation Reports: from (doctors' names) _____
   j. Other: *(must be specific)*_____
   k. Special instructions or limitations:_____

6. **This health information shall be disclosed to** and used by the following individual or organization: (**Please print**)

RELEASE TO	
	Name of Individual or Organization
	Individual or Organization Address (No. and Street, City, State, Zip Code – Phone #)
	For the purpose of (**REQUIRED**):

7. This authorization will **expire** in sixty (60) days unless another expiration date is specified here: __/__/__. *(mm/dd/yyyy)*

STATEMENT OF UNDERSTANDING: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the DOH Chief Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment from DOH. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the rediscosure may not be protected by federal confidentiality rules. I have a right to limit the information disclosed. A faxed copy of this release is acceptable for releasing PHI.

To revoke this authorization or if you have a question about disclosure of your health information, contact the Director of Medical Records at 330-332-7345 or the Compliance Officer • Salem Regional Medical Center• 1995 E State St•Salem, Ohio•44460 – phone 330-332-7855

SIGNATURES		
	Signature of patient or Personal Representative	Date (mm/dd/yyyy) / /
	If Signed by Personal Representative, Relationship to patient	
	Signature of Witness:	Date (mm/dd/yyyy) / /

Patient Name: _____ Medical Record #: _____

Patient's ID _____ Staff Initial: _____