Request for Records
Authorization for Use and Disclosure of Protected Health Information

Requesting from: _____ **Specialty:** _____

PATIENT IDENTIFICATION:
Name: _____ Date of Birth:_____
Address:_____
_____
SSN: _____ Telephone (__)_____

DATES OF TREATMENT TO BE RELEASED:
From (date): _____
To (date): _____
All Records [ ]

RECIPIENT INFORMATION:
Name: Salem Pain & Spine Specialists
Address: 1100 22nd Street SE, Salem Oregon 97302
Telephone: (503) 967-6771 Fax: (503)385-8421

PURPOSE OF REQUEST:
[ ] Treatment or Consultation
[ ] At the request of the patient
[ ] Other: _____

TYPE OF INFORMATION TO BE RELEASED:

[ ]Chart Notes
[ ] Procedure report
[ ] Prescription/Medication records
[ ] History & Physical exam
[ ] Consultation reports
[ ] Radiology reports

Other: _____

Time Limit & Right to Revoke Authorization - Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Salem Pain & Spine Specialists. Unless revoked, this authorization will expire in 180 days or on the following date or event: _____

Release of Specially Protected Health Information - I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. Initial YES ___ Initial NO ___

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability or for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that Salem Pain & Spine Specialists may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorized Salem Pain & Spine Specialists to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Relationship if not the patient: _____

Identity of requestor verified by whom: _____
_____Photo ID
_____Matching signatures
_____Other: _____

Identity of recipient verified by whom: _____
_____ Photo ID
_____Matching signatures
_____Other: _____

Signature of Recipient: _____ Date: _____