FORM 104 - R170621

## Medical Records Release

Patient Name		Date of Birth _	Date of Birth			
Information to Disclose						
Purpose of Disclosure:	transfer  dther					
RELEASE FROM		RELEASE T	0			
Name		Name	Name			
Address		Address				
City	State Zip	City		State	Zip	
Phone	Fax	Phone		Fax		
I HEREBY AUTHORIZE SALEM PEDIATRIC CLINIC TO USE AND DISCLOSE THE SPECIFIC PROTECTED HEALTH INFORMATION DESCRIBED ABOVE TO THE RECIPIENT FOR THE PURPOSES OUTLINED. 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 IF I PLACE MY INITIALS IN THE APPLICABLE SPACE NEXT TO THE TYPE OF INFORMATION ( <b>BE SURE TO MARK WITH YOUR INITIALS ONLY</b> ):			PATIENT INFORMATION YOU DO NOT NEED TO SIGN THIS AUTHORIZATION. REFUSAL TO SIGN THE AUTHORIZATION WILL NOT ADVERSELY AFFECT YOUR ABILITY TO RECEIVE HEALTH CARE SERVICES OR REIMBURSEMENT FOR SERVICES. THE ONLY CIRCUMSTANCE WHEN REFUSAL TO SIGN MEANS YOU WILL NOT RECEIVE HEALTH CARE SERVICES IS IF THE HEALTH CARE SERVICES REPRESENT RESEARCH RELATED			
HIV/AIDS			TREATMENT AND THE AUTHORIZATION IS NECESSARY TO PARTICIPATE IN THE RESEARCH STUDY AND RECEIVE			
GENETIC TESTING			RESEARCH RELATED TRE	ATMENT.		

\_ALCOHOL/CHEMICAL DEPENDENCY DIAGNOSIS, TREATMENT, OR REFERRAL

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER BE PROTECTED UNDER FEDERAL LAW. HOWEVER, I ALSO UNDERSTAND THAT FEDERAL OR STATE LAW MAY RESTRICT REDISCLOSURE OF HIV/AIDS INFORMATION, MENTAL HEALTH INFORMATION, GENETIC TESTING INFORMATION AND DRUG/ALCOHOL DIAGNOSIS, TREATMENT OR REFERRAL INFORMATION AND SPECIFICALLY REQUIRE MY AUTHORIZATION PRIOR TO REDISCLOSURE.

I HAVE READ THIS AUTHORIZATION AND I UNDERSTAND IT.

YOU MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. IF YOU REVOKE YOUR AUTHORIZATION, THE INFORMATION DESCRIBED ABOVE MAY NO LONGER BE USED OR DISCLOSED FOR THE PURPOSES DESCRIBED IN THE WRITTEN AUTHORIZATION. ANY USE OR DISCLOSURE ALREADY MADE WITH YOUR PERMISSION CANNOT BE UNDONE, TO REVOKE THIS AUTHORIZATION, PLEASE SEND A WRITTEN STATEMENT TO SALEM PEDIATRIC CLINIC, 2478 13TH ST SE SALEM OR 97302, AND STATE YOU ARE REVOKING THIS AUTHORIZATION.

Signed by \_\_\_\_\_

Date

Print Name \_\_\_\_

Relationship to Patient \_\_\_\_\_

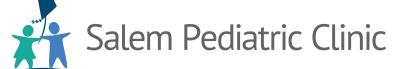
Unless revoked, this authorization expires (insert applicable date or event) \_

SPC ONLY

Date Released \_\_\_\_\_

Released by \_\_\_\_\_

\_\_\_\_



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