FORM 115 - R170621

Authorization to Use and Disclose Protected Medical Information for Electronic Disclosure

Patient Name _____ **Date of Birth** _____

THESE ARE THE ONLY CATEGORIES OF HEALTH INFORMATION THAT WILL BE DISCLOSED ELECTRONICALLY WITH THIS RELEASE:

- ALLERGIES
- MEDICATIONS
- DIAGNOSES
- REFERRALS OR CONTINUITY OF CARE FROM HOSPITAL / ER

THE INFORMATION WILL BE DISCLOSED TO COVERED ENTITIES, WHICH INCLUDE OTHER CLINICS AND PHYSICIANS FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AS OUTLINED BY HIPAA.

THE FOLLOWING CATEGORIES OF HEALTH INFORMATION WILL NOT BE DISCLOSED ELECTRONICALLY WITH THIS RELEASE — THIS PROTECTED HEALTH INFORMATION WILL REQUIRE A SEPARATE AUTHORIZATION:

- MENTAL HEALTH
- HIV
- DRUG AND ALCOHOL
- SEXUALLY TRANSMITTED DISEASES

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 TREATMENT AND THE AUTHORIZATION IS NECESSARY TO PARTICIPATE IN THE RESEARCH STUDY AND RECEIVE RESEARCH RELATED TREATMENT.

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.

YOUR SIGNATURE STATES THAT YOU HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

Signed by _____ **Date** _____

Print Name _____ **Relationship** _____

Email Address for Patient Portal _____

SPC ONLY

PCP _____

R _____ **D** _____

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