SRMC Plastic Surgery
A Service of SALEM REGIONAL MEDICAL CENTER

2094 E. State St., Suite G,
Salem, OH 44460
Phone: 330-332-7383
Fax: 330-337-9298

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name :_____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information from SRMC Internal Medicine Center be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following protected health information to be released from my medical record(s):
Immunization Record
Office Visit Records
Test Result(s) of: _____
Itemized Billing Records
Other: _____

State and/or federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates of service where appropriate):

Alcohol, Drug, or Substance Abuse Records: □Yes □No Dates: _____
HIV Testing and Results: □Yes □No Dates: _____
Mental Health: □Yes □No Dates: _____
Psychotherapy Records: □Yes □No Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR**
All past, present and future encounters/visits

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other *(please specify other on line below):*
_____

Disclosure Format (Paper is default if not marked.): US Mail – paper format Fax (healthcare provider only)
E-mail (secure format) E-mail (unsecure format, i.e., Gmail, Yahoo) CD/Flash drive – secure format Other *(please specify):*
_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to my physician's office. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. **If I fail to specify an expiration date/event/condition, this authorization will expire *90 days* from the date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by the federal Privacy Rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Witness: _____ ***Account #*** _____ ***Medical Record #***_____