Neurology Center of Salem

A Service of SALEM REGIONAL MEDICAL CENTER

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Phone: (330) 337-4940 Fax: (330) 337-6947

Patient Name:_____

Date of Birth:_____ **Telephone Number:**_____

Address:_____

I hereby authorize the use or disclosure of personal health information as described below:

1. Party authorized to disclose information **2. Party authorized to receive information**

_____ _____

_____ _____

3. Description of information that may be disclosed: _____ Entire Medical Records,
Other:_____

I understand and acknowledge that the medical records may contain information regarding psychiatric disorder, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, Alcohol and/or Drug Dependence/Abuse.

4. This information will be used for the following: _____

I understand that if the person or entity that receives the above information is not a health care provider or health care covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand the physician will receive no compensation for use/disclosure of the information unless I have been informed of such arrangements and indicated agreement by initialing this section.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits, unless treatment is for Research proposes or unless the provision of treatment is related solely to the disclosure of my protected health information to a third party. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken by the physician in reliance on this authorization, by sending a written revocation to Neurology Center of Salem.

_____ _____
Signature of Patient or Patient Representative **Date**

_____ _____ **Check Here if permissible to Fax**
Printed Name of Patient or Representative