Salem Radiology Consultants, P.C.

AUTHORIZATION to Use or Disclose Health Information

HIGHLIGHTED AREAS ARE REQUIRED

I authorize Salem Radiology Consultants, P.C. and/or Oregon Community Imaging, LLC to use and disclose a copy of the specific health and medical information described below for:

_____ _____

(Name of patient) (Maiden or prior name exams could be filed under)

_____ _____

(Date of birth) (Phone(s) number where you can be reached)

Please check type of exam: ☐ Mammography ☐ Ultrasound ☐ MRI ☐ CT ☐ X-ray or DEXA

☐ Other: _____

Release Films and Reports FROM: (facility name) _____

_____ _____ _____ _____

Facility Address City State Zip

Facility Phone: _____ Facility Fax: _____

(If known) (If known)

For The Purpose of: (Check all that apply) ☐ Further Medical Care ☐ Legal Investigative/Action ☐ Personal (at my request)

Authorization to request and use information

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy**. Unless otherwise revoked, this authorization will expire on the following date:_____. If I fail to specify an expiration date this authorization will expire 1 year from the date signed**. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

By: _____ _____

Signature of Patient/Parent/Guardian or Authorized Representative Date

(Guardian or Authorized Representative must attach documentation of such status.)

Please Send Images and Reports (CD, Powershare, or electronic transfer in DICOM FORMAT ONLY) To:
Salem Radiology Consultants, PC ● Medical Records Department ● 2925 Ryan Drive SE ● Salem, OR 97301
Medical Records Phone: 503-399-1262 Fax: 503-576-5906
MedicalRecordsDepartment@salemradiology.com

For internal use only: Jacket #: _____

PLEASE SCAN INTO PATIENT FILE/FILEBOUND AND PROVIDE COPY TO PATIENT AT TIME OF SIGNATURE

Notes: