Authorization for Release of Protected Health Information (PHI)
Salem Surgical Associates

Patient Name: _____ Date of Birth: _____

SECTION A (Must be completed for all Authorizations)

1. I hereby authorize the use or disclosure of my individually identifiable protected health Information (PHI) as described below. I understand and agree that this Authorization is voluntary. I understand that if the organization authorized to receive the Information is not a health plan, healthcare clearinghouse or health care provider covered by federal privacy regulations, the released Information may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient.

   Specific description of Information covered by the Authorization including dates: _Office notes, Progress Notes, Diagnoses, Operative Reports, Pathology, Imaging Reports, Lab reports_____
   _____

   Persons/Organizations authorized to make the disclosure or use of the Information: _____
   _____Salem Surgical Associates – 1898 Braeburn Dr. Salem VA 24153_____
   _____(540)772-3008_____Fax: (540) 772-3352_____

   Persons/Organizations to whom disclosure of the Information is to be made: _____
   _____
   _____

   The specific purpose of the use or disclosure of the Information is: __Submission of FMLA or Short Term Disability Paperwork_____

2. I understand that I may see and receive a copy of the Information described on this Authorization if I request it in writing, and I have the right to a copy of this Authorization.
3. I understand that I have the right to refuse to sign this Authorization.
4. This Authorization will expire on: Date: _____
   or Event: __Surgery and recovery_____
5. I understand that I may revoke this Authorization at any time by notifying Salem Surgical Associates in writing, except to the extent that Salem Surgical Associates has taken in reliance on this Authorization.

_____ _____ _____
Signature of Patient or Patient's Representative Date Time

_____ _____
Printed Name of Patient or Patient's Representative Relationship of Representative to Pt.

Evidence of the authority of the patient's representative (attach evidence to last page of Authorization):
_____