



Childhood Health Associates of Salem

891 23rd St. NE
Salem, OR 97301

Form B: Authorization to Use/Disclose Health Information

I authorize Childhood Health Associates of Salem to use and disclose a copy of the specific health and medical information described below regarding:

(Name of patient): _____ DOB: _____

consisting of: _____

to: _____
(Name, address and phone # of recipient or class of recipients)

for the purpose of: _____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed *Authorization* unless your health care or treatment is for the purpose of:

1. Creating health information about you to be disclosed to a third party; or
2. For the purpose of research.

You have the right to revoke this *Authorization* at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this *Authorization*, please send a written statement to Ingrid Hogenstad at 891 23rd Street NE, Salem, Oregon 97301 that identifies the date you signed this *Authorization*, the recipient of the information identified in this *Authorization*, and states that you are revoking this *Authorization*.

This *Authorization* will expire on the earlier of either _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this *Authorization*. I also understand that the information used or disclosed pursuant to this *Authorization* may be subject to re-disclosure by the recipient and no longer be protected under federal law.

<p><i>Foster parents: Please, initials only!</i></p> <p>By: _____ Date: _____</p> <p>(Patient's foster parent, if patient under 15)</p>	<p>NOTE: If initialed by a foster parent, this authorization is valid only for release of immunization records to school administration. Foster parents do not have parental HIPAA rights for foster children in their care.</p>
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—OR—

By: _____	Date: _____
(Patient, if aged 15 or more years)	

—OR—

By: _____	Date: _____
(Patient's legal representative, if patient under 15)	
Representative's authority (e.g. parent, legal guardian): _____	