891 23rd Street, N.E., Salem, OR 97301 Ph# (503) 364-2181 Fax# (503) 364-0364

Form B: Authorization to Receive Health Information

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

Name of Patient: ____ DOB: ________________

Consisting of: Complete Medical Records_____Specific records regarding:____________________________

To release Specially Protected Information, please initial where appropriate:

____Mental Health (inc. ADHD/ADD), **if patient over 14**, they must initial

____Alcohol/Chemical Dependency, **if patient over 14**, they must initial

____Sexually Trasmitted Diseases, **patient** must initial ____Birth Control, **patient** must initial ____Genetic Information

____HIV/AIDS

____
Signature of person initialling above

To: Childhood Health, 891 23rd St. N.E., Salem, OR 97301

From: Name of Doctor:____

Name of Clinic:____

Address of Clinic:____

____

Phone# of Clinic:__________________________________Fax # of Clinic:____________________

For the purpose of: Transfer of Care______Or write in reason_______________________________________
(Check Transfer of Care if request is for the purpose of starting care with new doctor or 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 St. NE, Salem, OR 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 of 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.

By:____ Date:_________________________
(Patient)

By:____ Date:________________________
(Patient's legal representative)

Representative's authority (e.g. parent, legal guardian):____