SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

Form 2A-1

Disclosure of PHI and Treatment, Payment, and Health Care Operations

Under the HIPPA Privacy Rule, Salem Pulmonary Associates, PC may disclose protected health information (PHI) for treatment, payment, or health care operations without permission from an individual under the following circumstances:

1. **For our treatment, payment, or health care operations (TPO)**
2. **For treatment activities of another health care provider**
3. **For the payment activities of another covered entity or health care provider, as long as the recipient of the PHI is that covered entity or health care provider**
4. **For purposes of health care operations, between covered entities participation in an organized health care arrangement (OHCA)**

The terms, treatment, payment, and health care operations, as well as health care provider and covered entity have specific meanings that must be understood before disclosure. Please read Form 2B-1 (Spa Office) for more information regarding your rights. Please see our Privacy Officer for an explanation of these terms.

I understand that during the course of normal business, Salem Pulmonary Associates, P.C. and Sleep Center may need to electronically transmit (fax) my medical records. I hereby authorize such transmission and absolve Salem Pulmonary Associates, P.C. and Sleep Center, its physicians, and its employees of any liability relating to such transmission of records.

If you have any questions regarding the permissibility of the disclosure or use of the information, please contact our Privacy Officer: Mark Harrison (503)588-3945.

ACCEPT: __________ **DO NOT ACCEPT: __________**

____ _____________________________________
Signature of Individual Authorizing Release of Information **Printed Name**

_____/_____/_____ ___________________
Date of Birth **Date**

I hereby authorize the use and/or disclosure on my PHI with the person or person's listed below: I give permission for them to receive and have access to my PHI. I understand that this authorization is voluntary and is not part of my treatment.

Name: ____ **Relationship:** _____________________________________

Name: _____________________________________ _____ **Relationship:** _____________________________________

Name: _____________________________________ _____ **Relationship:** _____________________________________

- **You may revoke this authorization at any time by providing written notice to:**
  Salem Pulmonary Associates, P.C. and Sleep Center 801 Mission St SE, Salem, Or 97302-6222.
- **Your revocation will not affect any actions already taken in reliance on this authorization.**
- **You are entitled to receive a copy of this authorization upon request**