Authorization to Use, Disclose, and Release Protected Health Information

Patient Information: *This form must be completely filled out, and signed and dated*

Patient Name (Please print full name): _____ Date of Birth: _____

Address: _____ Phone: _____

MRN (if known): _____ Email: _____

Release Format: ☐ **Paper Copy** ☐ **Electronic Delivery** ☐ **Electronic Hard Copy** (CD-ROM) ☐ **Verbal Discussions Information to be released from:** Cancer Care Northwest [ ] **If electronic please provide email address:** _____
Other: Name of person/Name of Organization: _____

Address: _____

Phone: _____ Fax: _____

Information to be released to: [ ] **Cancer Care Northwest: 1204 N Vercler RD, Spokane Valley, WA 99216**

Other: Name of person/Name of Organization: _____

Address: _____

Phone: _____ Fax: _____

The Purpose of the Release: ☐ Continuation of Medical Treatment: ☐ Personal Use ☐ Legal ☐ Billing ☐ Insurance ☐ Military ☐ Other

_____

Select the type(s) of information that may be released/disclosed:

☐ Office Visit Notes ☐ Laboratory Reports ☐ Medication Record ☐ Radiology Reports ☐ Radiology Images and Films
☐ Orders ☐ Billing Records ☐ Entire Record ☐ Other, please explain _____
☐ Specific Dates of Service or Condition-related Information, _____
☐ **Verbal Communication only about my medical history and care**

Special Information: I authorize the inclusion of the following information with this release **(initial all that apply)**

_____ Sexually Transmitted Infections, including HIV/AIDS _____ Psychiatric, mental, or behavioral health information
_____ Substance Use Disorder (SUD) _____ Genetic information indicators

*** ***Note:*** If this section is not completed, records of this type (if they exist) **will not** be released. ***

I understand the following

Once Cancer Care Northwest releases your health information, the recipient may re-disclose that information and privacy laws may no longer protect it. Some information, such as substance use disorders or mental health may still be protected.

1. I can refuse to sign. Cancer Care Northwest does not require you to complete this authorization to receive healthcare or healthcare benefits. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive health care information.
2. There may be a fee associated with this request. I understand this request for records may result in charges. I understand I will be contacted with an estimate of those charges before the records are produced.
3. I have the right to receive a copy of this authorization.
4. I have the right to revoke this authorization. I can withdraw this authorization in writing at any time. If I withdraw my authorization, it will not change actions that were already taken according to the authorization. To revoke contact CCNW HIM Department.

Expiration: This authorization is valid for **90 days** from the date that it is signed or until the date or event that is specified here:_____

Patient/Representative: _____ Date/Time: _____

Patient/Representative Name (**Print**): _____ Relationship: _____

Minor Signature (if required) _____

For CCNW Use Only:

Date Received: _____ Accepted: _____ Denied: _____ If Denied Reason: _____ Date Completed: _____ Staff Initials: _____