CancerCare NORTHWEST

REQUEST FOR
RELEASE OF RECORDS

Purpose for Use or Disclosure: **Continuity of Care**

I, (Print) _____, Date of Birth: _____request and authorize a copy of my protected health information (as described below) be sent to:

Cancer Care Northwest
Attn: HIM Dept
1204 N. Vercler Rd, Spokane Valley, WA. 99216

Fax: 509-252-9300
Phone: 509-228-1000

(Initial) _____ I authorize the release and disclosure of my complete medical record to Cancer Care Northwest. I understand that by signing this authorization, I am giving permission for Cancer Care Northwest, to receive copies of my protected health information (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all conditions, including records that may contain information regarding mental health/psychiatric conditions, substance abuse, communicable diseases, including HIV and AIDS, genetic testing), unless I have documented otherwise below.

Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):

___ Substance abuse
___ Psychiatric (mental health)
___ Communicable diseases (including HIV and AIDS)
___ Genetic testing
___ Other (please specify) _____

Unless I revoke this authorization, it shall remain effective for **90 days** or until the specified date or event: _____

I understand that this authorization may be revoked in writing to: Cancer Care Northwest HIM Dept., 1204 N. Vercler Rd, Spokane Valley, WA 99216, at any time except to the extent action has already been taken prior to revocation. I understand that my treatment will not be conditioned on whether I sign this authorization.

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____ _____
Printed Name of Patient/Legally Authorized Representative Relationship