Cancer Care Northwest

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION **TO CCNW**

Ph: 509-228-1123 | **Fax:** 509-252-9316 | CCNWmedicalrecords@ccnw.net | **Mail:** 1204 N. Vercler Rd. Spokane Valley, WA 99216

Patient Name:	Date of Birth:
Patient's Address	
Patient Email:	Phone

I authorize the below listed provider/facility to disclose the above patient's protected health information to Cancer Care Northwest:

Medical Provider/ Facility/ Entity Name:		
Address of Provider/ Facility/ Entity:		
Telephone:	Email:	Fax:

Method of delivery (select one): ☐ Mail to 1204 N. Vercler Rd. Spokane Valley, WA 99216

☐ Fax to: 509-228-9300 ☐ Email Encrypted to: ccnwmedicalrecords@ccnw.net ☐ Verbal

Purpose of Disclosure (select one): ☐ Continuing Care ☐ Other:_____

Date(s) of service to be released (required information):

☐ All Dates of Service ☐ Date Range: _____ ☐ Specific Dates:

Information to be Disclosed: ☐ Entire Record ☐ Progress Notes and/or Consultation ☐ Imaging Reports

☐ Labs ☐ Pathology Reports ☐ Other specified information: _____

Sensitive Information will not be released unless specifically authorized by selecting each:

☐ **Genetic Testing** ☐ Substance Use Disorder Treatment or Referrals ☐ HIV/AIDS-related treatment

☐ Sexually Transmitted Disease Records ☐ Reproductive Health Records ☐ Mental Health Records

I understand this authorization will be in effect for up to one year from the date of signing unless otherwise specified. I also understand I may send a written request to CCNW to revoke this authorization at any time; however, records disclosed prior to any revocation are authorized by this release. I further understand that once records are disclosed in accordance with this authorization they may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. It has been explained to me that treatment, payment, enrollment or eligibility of benefits will not be conditioned upon my signing this authorization.

Patient's Signature Date Signed

Signature of Legally Authorized Representative Date

Printed Name of Patient/ Legally Authorized Representative

Relationship to Patient/ (POA, Court appointed, etc.)

FOR ONLINE ACCESS TO YOUR MEDICAL RECORD VIA MYCHART™, PLEASE ASK ANY CCNW STAFF MEMBER TO HELP YOU ENROLL