South Office
601 S Sherman St
Spokane, WA 99202
509-228-1000
800-866-9809
509-252-9300 fax

North Office
605 E Holland, Ste 100
Spokane, WA 99218
509-228-1000
800-784-1873
509-252-9300 fax

Valley Office
1204 N Vercler
Spokane Valley, WA 99216
509-228-1000
509-252-9300 fax

Downtown Office
910 W Fifth Ave, Ste 102
Spokane, WA 99204
509-228-1000
509-252-9300 fax

Administrative Office
1204 N Vercler
Spokane Valley, WA 99216
509-228-1000
509-252-9300 fax

cancercarenorthwest.com

PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
RELEASE OF INFORMATION to CCNW

Patient Name:____ Date of Birth:__________________

Previous Name if Applicable:____

NAME OF PROVIDER RELEASING INFORMATION :____

Street:
City/State/Zip Code
Phone/ Fax :

NAME AND ADDRESS OF PROVIDER TO RECEIVE INFORMATION:

Provider: _________________________ @ CANCER CARE NORTHWEST Fax #: 509-252-9316
Street:
City/State/Zip Code

Information to be released to Cancer Care Northwest:

□ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition: ____
- □ Health care information in my medical record for the date(s):______________________________
- □ Other (e.g. x-rays, bills), specify date(s):_______________________________________
- □ Health care information regarding testing, diagnosis and treatment of HIV (AIDS virus), sexually transmitted diseases, drug and/or alcohol use or psychiatric disorders/mental health
- □ Psychotherapy notes

The health information described above will be used and/or disclosed for the following purpose(s):

- □ At my request
- □ Other (specify)____

_____________________________________ _________________________________
Signature of Patient Date

If this authorization is signed by a patient's personal representative, on behalf of the patient, please complete the following:

______________________________________ _________________________________
Name of Personal Representative Relationship to Patient

This authorization ends:

□ On (date): ___________________ - OR - □ When the following event occurs: ___________________________
If no date or event entered, authorization expires 90 days from the date signed.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization at anytime in writing.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect my information.

Accepted _______	Denied _______	Completed Date: ____________	Staff Initials: ______