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
CancerCare NORTHWEST

Health Information Dept.
Ph. 509.228.1000
Fax 509.252.9316

PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
RELEASE OF INFORMATION - TO OTHERS

Patient Name:_____ Date of Birth:_____

Previous Name (if applicable):_____

Indicate the information you are authorizing be used and/or disclosed by 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): _____
- □ If I have been tested, treated or diagnosed with any sexually transmitted disease, HIV/AIDS, drug/alcohol abuse, and/or mental illness, I specifically authorize Cancer Care Northwest to release to the person or entity below all information or medical records relating to such testing, diagnosis and/or treatment.
- □ Psychotherapy Notes

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

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

Persons/organizations you are authorizing to *receive* the health information described above:

Name: _____

Address: _____City: _____ State:_____ Zip: _____

Phone: _____ Fax _____

_____ _____
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: _____