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

HEALTH INFORMATION ACCESS REQUEST FORM
RELEASE OF INFORMATION - PATIENT

Patient Name:_____ **Date of Birth:**_____

Previous Name (if applicable):_____

You have the right to inspect and copy your health information, which is kept in a designated record set, because it may be used to make decisions about your health care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances.

Indicate the information to which you are requesting access to:

□ 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 all information or medical records relation to such testing, diagnosis and /or treatment.
□ Psychotherapy notes

I wish to inspect or obtain a copy of the requested information in the following manner:

□ fax □ mail □ electronic □ view information on-site □ office pick up

Copies of your health information will be provided to you at no charge. Charges will apply for copies requested for third parties.

_____
Patient Signature Date

_____
Name of Personal Representative (if appropriate) Signature of Personal Representative

For Cancer Care Northwest Use Only:
Date Received: _____ Accepted _____ Denied _____ Date Completed: _____ Staff Initials: _____

If denied, check reason for denial:
Excepted Information _____ Confidentiality Issues _____ Privacy Laws _____ Research _____
Other: _____

Date and method of informing individual of original decision: _____

If denied, was review requested? Yes _____ No _____

Name of reviewing official: _____ Decision on review:_____

Date and method of informing individual of review decision: _____

Comments:_____

_____ _____
Staff Member Signature Date