Salish CANCER CENTER

The Puyallup Tribe's Integrative Approach to Healing

Please use a pen to complete all sections of this form.

_____

Patient Name (Last, First, Middle)

_____

Date of Birth

_____

Social Security Number

_____

Patient's Address

_____

City, State

_____

Zip Code

_____

Phone Number

Notice to Patient: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

Please complete all sections of this form immediately and fax it to

253-382-6301

Authorization Form

I hereby authorize Salish Cancer Center to obtain information from:

All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities.

Information released from providers listed above should be sent to Salish Cancer Center, 3700 Pacific Highway, Suite 100, Fife, WA 98424

This consent is allowed to be acted upon up to one year from the date of signature, unless a shorter time is specified by the patient or their representative. This authorization will remain in effect until the:
_____ day of_____ , 20_____ or until the following event occurs:

_____

_____.

I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity, and release Salish Cancer Center, its agents and employees from any liability in connection with the release of information contained therein. I understand that I may at any time make a written request to inspect and/or obtain a copy of my health information and that Salish Cancer Center will, within 45 days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any) and instructions as to how and to whom I may register a complaint regarding the denial. I may contact the Salish Cancer Center by mail at the address above or by telephone at **253-382-6300**.

Specify information to be disclosed for treatment dates _____ to_____

The information disclosed will be limited to the following as marked:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Oncology Records
- ☐ Rehabilitation Notes
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Pathology Slides
- ☐ EEG
- ☐ EKG
- ☐ ER Reports
- ☐ Abstract of Chart
- ☐ Imaging Reports & Films
- ☐ Consultation
- ☐ Naturopathic Notes
- ☐ Medication Summary
- ☐ Laboratory Reports
- ☐ Chemotherapy Flowsheet
- ☐ Chemotherapy Records
- ☐ Radiation Therapy Records & Notes
- ☐ Other (specify) _____

_____

Highly Sensitive Information:

By **initializing the blank** next to a category of highly sensitive information listed below, I specifically authorize the use and/or disclosure of the indicated category, if any such information exists:

_____Mental Illness or Developmental Disability

_____Physcotherapy Notes (requires provider consent)

_____Substance Abuse or Diagnoses (e.g., alcohol or drugs)

_____Genetic Testing

_____Abuse of an Adult with Disability

_____Sexual Assault

_____Child Abuse and Neglect

_____Sexually Transmitted Disease

_____HIV / AIDS testing or treatment
(including the fact that an HIV test was ordered, performed or reported regardless of the results)

For the following purpose and that purpose only:

☐ Continued Treatment ☐ Personal ☐ Other (specify)_____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my protected health information. By my signature, I hereby knowingly and voluntarily authorize Salish Cancer Center to use or disclose my health information in the manner as described above.

_____

Patient Signature (if patient is unable to sign, indicate reason (e.g., minor or medically incapacitated)) Date

_____

Parent / Guardian / Other Legal Representative (Provide copy of legal document and specify relationship to patient) Date

_____

Witness (Witness signature required for release of information about a mental illness) Date