## SALISH CANCER CENTER (SCC) AUTHORIZATION TO USE AND DISCUSS HEALTH INFORMATION

*3700 Pacific Highway E. • Suite 100 • Fife, WA 98424 • (253) 382-6300 • Fax (253) 382-6301*

### PATIENT INFORMATION:

Name: _____ Date of Birth: _____ SSN: _____

Sex: _____ Email: _____

Phone Number: (H) _____ (W) _____ (C) _____

**Patient Initials:** _____

*By initialing above, I authorize SCC and listed agencies or persons below to leave detailed messages on the phone numbers provided above.*

### AUTHORIZATION:

- I authorize SCC to use, exchange and/or discuss my demographic and health information during the term of this Authorization for the following specific purpose(s): treatment, payment, services, clinical coordination and/or health care operations. I understand that in order to facilitate secure transmission of information and proper identification, SCC and listed agencies or persons will exchange my personal identification information possibly including but not limited to legal name, date of birth, insurance carrier information, social security number, sex, and contact information.

### RECIPIENT(S)

- Name of Agencies or Persons with whom SCC may use, exchange and/or discuss my health information:

| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
|---|---|---|
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (optional field): | | |
| | | |
| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (if a specific person is listed, please provide date of birth and relationship): | | |

- To list more agencies/persons, please request an additional "Recipient" sheet from front office staff.

## PATIENT INFORMATION:

Name: _____ Date of Birth: _____ SSN: _____

## SPECIFY INFORMATION TO BE DISCLOSED:

- By initialing listed sections, I authorize SCC to use, exchange and/or discuss my demographic and health information as specified below:

Initial: _____: Medication and Allergy Lists
Initial: _____: Lab Orders and Results
Initial: _____: Imaging Orders and Results
Initial: _____: Clinical Prognosis and Treatment
Initial: _____: Immunization History
Initial: _____: Current and Past Treatments
Initial: _____: Treatment Plans
Initial: _____: Chart Notes and Summaries
Initial: _____: H&P
Initial: _____: Mental Health Care Records

## AUTHORIZATION EXPIRATION:

- This authorization will expire one-year from the date of signature unless otherwise specified. I understand that I may revoke this authorization in writing at any time to the Medical Director at 3700 Pacific Hwy E., Suite 100, Fife, WA 98424 except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or *expiration event:*

Date of Expiration: _____ Date of Expiration (if other than one year): _____

## PATIENT CONSENT

- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of SCC's treatment of me except if that care is (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.
- I understand that once SCC discloses my health information to the recipient, SCC cannot guarantee that the recipient will not re- disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and WA law governing the use and disclosure of my health information.
- 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 health information. By my signature, I hereby knowingly and voluntarily authorize SCC to use and/or discuss my health information in the manner described above.

Signature of Patient: _____Date: _____

- Note: If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Legal Guardian or POA: _____

Printed Name of Signee: _____Relationship to Patient: _____

Date: _____ Contact Information for Signee: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____Relationship to Patient: _____

**PATIENT INFORMATION:**

Name: _____ Date of Birth: _____ SSN: _____

**RELEASE OF INFORMATION: ADDITIONAL RECIPIENT SUPPLEMENTAL PAGE**

- This page to accompany two-page release document and is not a standalone release authorization.

**RECIPIENT(S)**

- Name of Agencies or Persons with whom SCC may use, exchange and/or discuss my health information:

| | | |
|---|---|---|
| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (optional field): | | |
| | | |
| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (if a specific person is listed, please provide date of birth and relationship): | | |
| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (optional field): | | |
| | | |
| Person/Provider Name: | Person/Provider Type/Specialty: | Person/Provider Phone: |
| Person/Provider City: | Person/Provider Fax: | Point of Contact Name: |
| Notes (if a specific person is listed, please provide date of birth and relationship): | | |