Authorization for Disclosure of Health Care Information

(Salish Cancer Center Peer Support Program)

I, the individual identified below, hereby grant permission to the Salish Cancer Center (the "SCC") to disclose my protected health information ("Health Information") to one or more Program participants, including patients of SCC and their caregivers, if applicable (collectively, "Participants") for the purpose of my participation in the Salish Cancer Center Peer Support Program (the "Program"). I understand that the Participant(s) will use my Health Information to contact me regarding the Program.

I understand that my Health Information that will be disclosed to the Participant(s) under this Authorization contains personal information about me, including my name, contact information, and the fact that I am affiliated with SCC, that is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that my Health Information cannot be disclosed without my written consent unless otherwise permitted under HIPAA.

I understand that my Health Information may be subject to re-disclosure by any person receiving the Health Information and may no longer be protected by applicable law. I understand that I may revoke this Authorization by notifying SCC in writing at: 3700 Pacific Hwy E, Suite 100, Fife, WA 98023, Attn: Social Work Manager. However, I understand that any action already taken in reliance on this Authorization cannot be reversed and my revocation will not affect those actions.

I understand that SCC may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

I have read this Authorization and understand its contents are legally binding**.**

Name (print): _____

Signature: _____ **Date:** _____