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

❖ **Patient Information:**

| | | |
|---|---|---|
| Name: | Date of Birth: | SSN: |
| Email Address: | | |
| Phone Number: ☐(H) | ☐(W) | ☐(C) |

*Please check preferred method of contact.* ***May we leave a detailed message?*** ☐ ***YES*** ☐ ***NO***

❖ **PURPOSE:** I authorize SCC to use and/or discuss my health information during the term of this Authorization for the following specific purpose(s): treatment, payment, and/or health care operations.

❖ **RECIPIENT:** Name of person(s) to whom SCC may use and/or discuss my health information:

| | | |
|---|---|---|
| **Name:** | Date of Birth: | Relationship: |
| Phone Number: ☐(H) | ☐(W) | ☐(C) |
| **Name:** | Date of Birth: | Relationship: |
| Phone Number: ☐(H) | ☐(W) | ☐(C) |
| **Name:** | Date of Birth: | Relationship: |
| Phone Number: ☐(H) | ☐(W) | ☐(C) |

❖ **SPECIFY INFORMATION TO BE DISCLOSED:** I authorize SCC to use and/or discuss the following information:
☐**Medication Lists** ☐**H&P** ☐**Labs** ☐**Imaging** ☐**Prognosis** ☐**Treatment Care Plan** ☐**Chart Notes/Visits**

☐ All dates or ☐ Only the period of events from _____/_____/_____ to _____/_____/_____.

Specific information not to be used and/or discussed:_____

❖ **Please read the following statements carefully:**
I understand that I may revoke this authorization in writing at any time to the Practice Administrator 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or *expiration event:*
*Indicate date or event if different than one year after the date below* _____

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 | Relationship to Patient | Date | Witness