(staff may use patient label below)

SCCA Medical Records Request

Patient name (last name, first name): ______________________________

Date of birth or **medical record number (U#):** ______________________

1. **I give permission for SCCA to:** (check only one):

☐ **Talk** to my family, friends or others about my care

☐ **Give** my medical records to an outside facility/person/me

☐ **Gather** my medical records from an outside facility/person

Fill in this chart for the above request

Person/facility List physician(s), family member(s), friend(s), etc.	**Phone number**	**Other contact information** List address, email and/or fax #	**How would you like info released?** Mail, email, fax, verbal, other?

2. **Please let us know why you're requesting this information:**

☐ Health care provider ☐ Personal ☐ Insurance ☐ Legal ☐ Other ___________

3. **Type of records** (check all that apply):

☐ Clinic notes ☐ Lab/pathology reports ☐ Radiology reports ☐ Imaging CD South Lake Union clinic only ☐ Other ___________

4. **Records within the following dates** (check one)

☐ Records between (write dates in mm/dd/yyyy) _____/_____/_____ and _____/_____/_____

☐ All of my records since the beginning of treatment

5. **Expiration date**

This form is only good for 90 days from the date you sign it unless you fill out the information below.

Stop sharing or getting my information:

☐ When I finish my treatment at SCCA ☐ On this date: _____/_____/_____ ☐ Other: ____________________

6. **Regarding sensitive information**

Adults: I understand that the information in my health record may include sensitive information related to HIV/AIDS, sexually transmitted infections, behavioral or mental health services, and/or treatment for alcohol and drug abuse.

☐ Do not share sensitive information related to sexually transmitted infections, including HIV/AIDS, mental health services, and treatment for alcohol and drug abuse with others.

Minors: A minor patient's signature is required in order to release the following information: Conditions relating to the minor's reproductive health, sexually transmitted infection (if age 14 and older), alcohol and/or drug abuse, and mental conditions (if age 13 and older).

Minor's signature: ____ Date: ____________________

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature (patient or authorized representative):	**Print name**	**Date (mm/dd/yyyy)**
If signed by person other than patient, provide relationship to patient and description of authority:		

SCCA Medical Records Request

Why do I need this form?
As required by law, Seattle Cancer Care Alliance (SCCA) complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes protecting the confidentiality of your information. In certain situations, we need your written permission to give your medical records to an outside facility/person, gather your medical records from an outside facility/person, or talk with your family, friends, or others about your care. If you wish to give SCCA permission to do any of these, please fill out the Medical Records Request form. You, as the patient, are not charged a fee for this.

If my health information is sent over email, how is it protected?
SCCA uses an email encryption service to ensure the confidentiality of the protected health information we send. SCCA also uses the service to comply with federal regulations under HIPAA. For more information about SCCA's Privacy Policy, please visit our website at www.seattlecca.org/privacy-policy.

What is protected health information (PHI)?
PHI generally refers to demographic information (race, ethnicity, gender, age, etc.), medical histories, test and laboratory results, mental health conditions, insurance information, and other data that a healthcare professional collects to identify an individual and determine appropriate care.

Potential for my health information to be given to someone else:
Once SCCA gives your health information to another person or facility, the law does not always require the recipient to maintain the confidentiality of your healthcare information.

What if I change my mind?
You may take away your permission to release your medical records by submitting a form to: SCCA Integrity Program, 825 Eastlake Ave East, M/S LG-600, P.O. Box 19023, Seattle, WA 98109 at any time. To get the form, email SCCA Integrity at integrity@seattlecca.org. If you take away your permission, it will not be effective if SCCA has already discussed, given, or received information based on the original records release, or if SCCA requires the information in order to be paid for treatment provided to you. You have the following rights:

- To inspect or to receive a copy of your protected health information
- To receive a copy of your signed records release
- To refuse to sign the records release

For questions about this process, please call the SCCA Integrity Program at 206-606-7154 or email integrity@seattlecca.org.

You also understand that giving SCCA permission to give or get your medical records is voluntary and is not meant to alter your ability to receive care at SCCA, except if: (1) You are participating in research-related treatment, such as a clinical trial; (2) SCCA is giving your PHI to a third party who has authorization.

Where do I send my completed form?
Submit your completed Authorization Form to the SCCA clinic that provides your care using the contact information below.

SCCA South Lake Union	SCCA at UWMC - Northwest	SCCA at EvergreenHealth	SCCA at Overlake Medical Center
Health Information Management PO Box 19023 MS: CE2-210 Seattle, WA 98109 Ph: (206) 606-1114 Fax: (206) 606-1035 release@seattlecca.org	Health Information Management 1560 N 115th St. Suite G16 Seattle, WA 98133 Ph: (206) 606-2794 Fax: (206) 606-6855 nwhhimfax@seattlecca.org	Health Information Management 12040 NE 128th St. MS: 98, Suite 1600 Kirkland, WA 98024 Ph: (425) 441-2644 Fax: (206) 606-8291 evgrelease@seattlecca.org	Health Information Management 1135 116th Ave NE Suite 250 Bellevue, WA 98004 Ph: (425) 635-6935 Fax: (425) 990-5309 belrelease@seattlecca.org
SCCA Issaquah		**SCCA Peninsula**	
Health Information Management 1740 NW Maple St. Suite 211 Issaquah, WA 98027	Ph: (206) 606-7907 Fax: (206) 606-4030 isqrelease@seattlecca.org	Health Information Management 19917 Seventh Ave Suite 100 Poulsbo, WA 98370	Ph: (360) 697-8000 Fax: (206) 606-5122 pccrelease@seattlecca.org

You can send the form via email, fax, regular mail, or in person at the clinic that provides your care. Feel free to call the phone numbers listed with any questions.