Seattle Cancer Care Alliance

Fred Hutch · Seattle Children's · UW Medicine

AUTHORIZATION FORM INSTRUCTIONS

Dear Sir or Madam:

I am sending you a blank Authorization for Disclosure of Health Information form.

Please completely fill out this form:

Section 1: Provide Patient Information: Patient Name, U Number and Date of Birth.

Section 2, question A: Check the appropriate box to indicate if you want SCCA to send your records to another facility or person, OR if you want another facility to send your records to SCCA.

Section 2, question B: Check the appropriate box to explain the reason that you want the records.

Section 2, question C: Provide the information for the person or organization to whom you want the information to be disclosed:

- In the 1st and 2nd columns, provide the name and phone number.
- In the 3rd column enter the information needed to send by the preferred delivery method: *complete mailing address*, email address or Fax number.
- In the 4th column enter the preferred medium for the information: Access, CD, email or paper.

Section 3: Provide beginning date (month/year) of records to be released and end date (month/year) of records to be released.

Select the information you wish to be disclosed. On the "other" box, write in pharmacy Co-pays if needed.

Section 4: Provide a date for the expiration of this authorization for release of records. If you do not enter a date the authorization will expire in 90 days from the date the document is signed.

Section 5: Please read this section, and mark the box if necessary. Sign and date the form.

To return the form:

SCCA at Northwest Hospital	**SCCA at Evergreen Hospital**
Email: nwhhimfax@seattlecca.org	**Email: evgrelease@seattlecca.org**
Fax: (206) 606-6855	**Fax: (206) 606-8291**
Phone: (206) 606-2794	**Phone: (425) 899-3188**
Mail to: Medical Records **1560 115th St. Suite G16** **Seattle, WA 98133**	**Mail to: Medical Records** **12040 NE 128th St.** **MS 98 Suite 1600** **Kirkland, WA 98034**

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION (1 of 2)

1. Patient Identifiers (Patients fill in both fields. Staff put label over both fields.)

Patient Name: _____

U# or Date of Birth: _____

SHIM007

2. Initial Information (Complete ALL steps)

A. Select one of the options below

☐ **Release** information from SCCA to Outside Facility/Person **(SCCA → Outside)**

☐ **Obtain** information from Outside Facility/Person to SCCA **(Outside → SCCA)**

☐ **Access** information includes verbal communication for caregivers or listed providers

B. Select the purpose of Release/Obtain request from the options below

☐ Continuing care (Provider/Facility) ☐ Personal Copy ☐ Insurance ☐ Legal

☐ Coordination of Care (Family/Caregivers) ☐ At the request of the individual

C. Complete the Outside Facility/Person Information

Person/Organization	**Phone**	**Preferred Delivery Method** - enter Email address, Fax #, or Street Address	**Pick up** paper copy
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

3. Information Type(s)

Date Range of Records Request: ____/____/____ to ____/____/____.

☐ Clinic Notes ☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Other: _____

4. Authorization Expiration Date (Expires in 90 days from date signed if a box is not checked)

☐ End of treatment

☐ Other: _____

5. Signature

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

☐ ***I wish to exclude from disclosure sensitive information related to sexually transmitted diseases, including AIDS, HIV, mental health services and treatment for alcohol and drug abuse.***

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

Minor 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 Patient's Authorized Representative):	**Print Name**	**Date**
If signed by person other than patient, provide relationship to patient and description of authority:		

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION (2 of 2)

Potential for Redisclosure:
Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your healthcare information.

Revocation:
I understand that I may revoke this authorization by submitting the revocation request in writing to: SCCA Integrity Program, 825 Eastlake Ave East, M/S LG-600, P.O. Box 19023, Seattle, WA 98109 at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where SCCA requires the information in order to be paid for treatment provided to me.
I understand that I have the following rights:

- To inspect or to receive a copy of my protected health information
- To receive a copy of this signed authorization
- To refuse to sign this authorization

I understand that SCCA or a requesting covered entity will not condition treatment or payment based on receipt of this signed authorization except: (a) SCCA may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; or (b) SCCA may condition healthcare that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected information to such third party; for example, when a non-SCCA employer contracts with SCCA to conduct TB testing purposes of employee health screening.

This authorization form can be sent to us by Email, Fax, USPS or SCCA Reception:

SCCA Release of Information (HIM)

SCCA at Northwest Hospital	SCCA at Evergreen Hospital
Email: nwhhimfax@seattlecca.org	**Email: evgrelease@seattlecca.org**
Fax: 206-606-6855	**Fax: 206-606-8291**
Phone: 206-606-2794	**Phone: 425-899-3188**
Mail to: Medical Records 1560 115th St. Suite G16 Seattle, WA 98133	**Mail to: Medical Records 12040 NE 128th St. MS 98 Suite 1600 Kirkland, WA 98034**

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Release of Information Form