

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Swedish Cancer Institute to disclose the following information from the health records of:

Patient Name: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) - \_\_\_\_\_

Birth date: \_\_\_\_\_ Dates of Medical Care: \_\_\_\_\_ - \_\_\_\_\_

### Protected health information to be disclosed:

- |  |  |
|--|--|
| <input type="checkbox"/> Verbal Disclosure only                      | <input type="checkbox"/> Progress (Chart) Notes      |
| <input type="checkbox"/> History & Physical                          | <input type="checkbox"/> Radiation Treatment Records |
| <input type="checkbox"/> Operative Report                            |  |
| <input type="checkbox"/> Diagnostic Studies (Labs, X-ray, EKG, etc.) | <input type="checkbox"/> Other _____                 |

To be disclosed to: \_\_\_\_\_

*Name of Person/Provider/Organization you authorize to receive the information*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( \_\_\_\_\_ ) - \_\_\_\_\_ - \_\_\_\_\_ Telephone \_\_\_\_\_ ( \_\_\_\_\_ ) - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_

For the purpose of: \_\_\_\_\_

I understand

- that this authorization, unless expressly limited by me in writing, **will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.**
- that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.
- that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment at Swedish.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Expiration date or event** \_\_\_\_\_ \*

\*Authorization for disclosure to a financial institution or employer of the patient for purposes other than payment for healthcare services expires 90 days after date signed.

Signed: \_\_\_\_\_ (Patient) Date: \_\_\_\_\_

\_\_\_\_\_  
(or Legal Representative and Relationship) Date: \_\_\_\_\_