



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The American Cancer Society's Patient Navigator will assist you in obtaining the resources you need throughout your cancer care at Swedish Cancer Institute.

The ACS Patient Navigator will assist you and/or your family to:

<ul style="list-style-type: none">• Understand your diagnosis, procedures and treatment• Obtain transportation, housing, and other financial assistance• Access complementary care, nutrition, social work, spiritual care, support groups and community services	<ul style="list-style-type: none">• Receive emotional support
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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:

Verbal

To be disclosed to:

**American Cancer Society Patient Navigator at Swedish Cancer Institute
1221 Madison Street Seattle, WA 98104
PH: (206) 215-6557 FAX: (206) 215-6199**

For the purpose of: Introduction and provision of support services available at Swedish Cancer Institute and in the community. The information being disclosed will assist the ACS Patient Navigator in providing information and care appropriate to your specific diagnosis.

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 Medical Center.

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: _____ Date: _____
(Patient)

Date: _____

(or Legal Representative and Relationship)