SWEDISH CANCER INSTITUTE

1221 Madison Street, 4th Flr
SCI Medical Records
Seattle, WA 98104
Ph: 206-386-3706
FAX 206-386-2311

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

Patient Name: _____
(Last, First, Middle)

Previous Name: _____
(Last, First, Middle

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____ Birth date: _____

Date(s) of Medical Care: _____ _____ _____

For the purpose of:	☐ **Verbal Disclosure only** to family members/caregivers ☐ Request for Continuing Care Release ☐ Other:

Information to be disclosed to: _____ *(Name)*

(One recipient only) _____ *(Attention)*

_____ (Address)

_____ *(City, State, ZIP)*

PH: _____ *FAX:* _____ *E-MAIL:* _____

Information to be disclosed:

☐ History & Physical
☐ Radiation Treatment Records
☐ Operative Report
☐ Diagnostic Studies (Labs, X-ray, EKG, etc.)
☐ Progress (Chart) Notes
☐ Other _____

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.

I understand 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.

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.

I understand 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.

Expiration date or event: _____

I understand 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. Unless otherwise revoked, this authorization expires in 90 days.

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(or Legal Representative and Relationship)