# Authorization form instructions

Dear patient and caregiver:

We are providing a form that has certain sections *prepopulated* to ensure Seattle Cancer Care Alliance (SCCA) can smoothly transfer all relevant information from Peninsula Cancer Center for the continuation of your care. Please follow the instructions below to complete the form.

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

**Section 2, question A:** *This section has been prepopulated to reflect that SCCA is obtaining records.*

**Section 2, question B**: *This section has been prepopulated to select Continuing Care.*

**Section 2, question C:** *The section has been prepopulated with Peninsula Cancer Center information.*

**Section 3:** Provide beginning date as first year of treatment at Peninsula Cancer Center (20XX) and write in (Present) for the end date of records to be released.
*Other box has been prechecked and 'All Records' has been prepopulated.*

**Section 4:** You may leave this section blank and default to having the Release of Information expiring at 90 days.

**Section 5:** Please read this section and mark the box if necessary. Please sign the document and date the form. (Electronic signatures are not accepted.)

Email to Doctors@peninsulacancercenter.com

- Fax it to 360-598-6227
- Mail to:

  Peninsula Cancer Center
  19917 7th Ave Ste. 100
  Poulsbo, WA 98370

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

**1.** **Patient Identifiers** (Patients fill in both fields, Staff may affix Label)

Patient Name: _____

*SHIM007* Release of Info

U# or Date of Birth: _____

**Initial Information (Complete ALL steps)**

**2.**

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 (***CD's available at SLU Clinic ONLY)**

| **Person/Organization** | **Phone** | **Preferred Delivery Method**-select Email address, Fax #, or Street Address | **Media Type-** If applicable, select CD* or Paper Copy |
|---|---|---|---|
| Peninsula Cancer Center | 360-697-8000 | 19917 7th Ave Ste 100, Poulsbo, WA 98370 | |
| | | | |
| | | | |

**3.** **Information Type(s)**

Date Range of Records Request:_____ _____

☐ Clinic Notes ☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Imaging CD (Radiology) ☑ Other:All Records

**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, or USPS :

E-mail:

Doctors@peninsulacancercenter.com

Fax: 360-598-6227

Phone: 360-697-8000

Mail:19917 7th Ave Ste. 100 Poulsbo,

WA 98370