Release of Personal Health Information Directive

TACOMA VALLEY RADIATION ONCOLOGY CENTERS
HEALTH | HEALING | HOPE
www.Defeatyourcancer.com

Name:_____
(First) (Last) (Date)

RE: Privacy Practices - Please read before signing.
Excerpt from Tacoma/Valley Radiation Oncology Center Privacy Practice Policy— Notification of Family and Others:
While we treat your protected health information with utmost respect and concern for privacy, unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information.

I, _____, hereby grant permission to physicians and staff or their employed contractor to share my personal health information to the *family and friends* listed below:

Name	Relationship	City / State	Phone Number

I acknowledge receipt of the Tacoma/Valley Radiation Oncology Center Privacy Practice Policy.

Signature: (Relationship to Patient) Date:

Print Name

If you object to protected health information being shared, please sign below:

Signature: (Relationship to Patient) Date: