PATIENT ACCESS TO RELEASE MEDICAL RECORDS

pacific medical centers

Phone: 206-621-4150
Fax: 206-621-4039
Mail: 1200 12th Ave S.
Seattle, WA 98144
Attn: HIM Dept.
Email: HIM@pacmed.org

Patient Name: _____ Alias: _____

Patient Address: _____ Unit/Apt: _____

City/State/Zip: _____ Phone: _____

Patient Birth Date: _____

For Office Use Only
MEDICAL RECORD #

Charges may apply.

☐ **PacMed sends ➔**
I request and authorize Pacific Medical Centers to release information to:

Person or Organization: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

☐ **PacMed receives ➔**
I am requesting information from the following facility:

Person or Organization: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

- **For the purpose of**: ☐ Legal ☐ Self ☐ Transfer of Care ☐ Other: _____

Date range from: _____ to: _____

- ☐ **Entire Record**
- ☐ Standard record set *(includes most recent 2 year Office notes, labs & radiology results)*
- ☐ Colonoscopy
- ☐ Eye Exam
- ☐ Lab Results
- ☐ Medication List—Current
- ☐ Radiology/Imaging
  - ☐ Results Only ☐ Images Email _____
  Radiology images only can be sent via email.
- ☐ Immunizations
- ☐ OTHER: Please specify with dates of service:

Terms:
This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Send my records via:
- ☐ MyChart
- ☐ Paper
- ☐ CD/Disc
- ☐ Email *(radiology images)*

I UNDERSTAND THE FOLLOWING:

- Authorizing the disclosure of health information is voluntary. I do not need to sign this form in order to assure treatment.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest under my policy.
- Unless I specify differently, this authorization will expire 12 months or one year from the date of the signature below.
- Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

AUTHORIZATION / SIGNATURES

Date: _____ Patient Signature: _____

Note: IF THE PATIENT IS 13 YEARS OR YOUNGER AND IS NOT AN EMANCIPATED MINOR, THE PARENT OR LEGAL GUARDIAN MUST SIGN AND PROVIDE PHOTO I.D TO COPY. **If the patient of any age is unable to sign for any reason, a legal representative must sign and provide a copy of the legal documentation.**

Date: _____ Signature: _____ **Relationship to Patient**: _____

Patient Access to Release Medical Records

You have the right to receive a copy of your health information that we maintain, with some limited exceptions. You have the right to request that your health information be sent to any person or entity.

Our Health Information Management Department can help you obtain a copy of your medical record. To start the process, you can complete an “Authorization to Release Patient Information” **OR** you can send us a written request, signed by the patient (or personal representative), which clearly identifies the patient, the recipient of the records (if different than the patient), and the address to send the records.

Please fax your completed form to **(206) 621-4039** or mail your form to:

Pacific Medical Centers
Attn: Health Information Management
1200 12th Ave South
Seattle, WA 98144
Phone: 206-621-4150
Fax: 206-621-4039

If you have any other questions or concerns, you can contact us at **(206) 621-4150** or write to us at the address above. Please include your full name, date of birth, and a contact phone number.

To request from other clinic/doctor medical records sent to Pacific Medical Centers
Coordinate with your PacMed doctor regarding which of your former records maintained at outside facilities are desired. Please contact the clinic/doctor where you received your care to coordinate the request for the release of information to go directly to PacMed.

IMPORTANT: Pacific Medical Centers no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient records that are more than a few years old. The records you are requesting may include your social security number.