SEATTLE/KING COUNTY CLINIC RECORDS REQUEST

AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

Seattle/King County Clinic will process all records requests at no cost to patients treated at the 2015, 2016, and/or 2017 Seattle/King County Clinic. Records from the clinic will be sent within 15 days of receipt of this completed records request form. All records from the 2014 Seattle/King County Clinic must be made to Remote Area Medical, details to process requests from the 2014 Clinic can be found at seattlecenter.org.

To release your records, complete and sign this records request form and mail or fax the completed form to:

Mailing Address: **Seattle/King County Clinic**
c/o Seattle Center
305 Harrison Street
Seattle, WA 98109

Fax Number: **206-684-4183**

I understand and agree with the following statements regarding this request:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information.
- I understand that this authorization will expire upon the completion of this request; additional requests will require separate authorization.
- I understand that information released to any person(s) not affiliated with a health care provider or health plan may not be protected under federal privacy rules and may be shared with others.

I authorize Seattle/King County Clinic to send a copy of the specific health information from the Seattle/King County Clinic as described below regarding:

Patient's Name: ____ Date of Birth: ___________________

Patient's Address: ____

City: ___________________________ State: _________ Zip: ______________ Phone: _____________________

Records from (check all that apply): ☐ 2015 ☐ 2016 ☐ 2017

To be sent (Name of Representative or Agency): ____

Recipient's Address: ____

City: ____ State: ______________ Zip: ____________________

Phone: __________________________ Fax: _________________________ Email: ________________________

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.

Patient Signature: ____ Date: _________________

Patient Representative Name: ____ Date: _________________

Representative Signature: ____________________________________ Relation to Patient: _________________

ADMIN USE ONLY Date Processed___________________ Initials______________

2015 ID #_____________________ 2016 ID #_____________________ 2017 ID #_____________________