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 Clinic and beyond. Records will be sent within 15 days of receipt of this completed records request form.

Records requests from the 2014 Seattle/King County Clinic must be submitted to Remote Area Medical. Details to process requests from the 2014 Clinic can be found at seattlecenter.org/patients.

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 St
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.
- This authorization expires upon completion of this request. Additional requests require separate authorizations.
- 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 year(s): ____

To be sent to (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 ________ By (Initials) _____ Patient ID #s _________