SEATTLE/KING COUNTY CLINIC

RECORDS REQUEST FORM
Authorization To Use, Disclose & Release Protected Health Information

Seattle/King County Clinic will process records requests at no cost to patients. Records will be sent within 15 days of receipt of this completed records request form.

For mammography or immunization records, find the records request links at seattlecenter.org/skcclinic/patient-records

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:

- 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 _____