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, use the request links at **seattlecenter.org/skcclinic/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 Foundation
305 Harrison Street, Seattle, WA 98109

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

I acknowledge and agree to the following statements regarding this request:

- This authorization will expire upon completion of the current request. Any additional requests will require a separate authorization.
- If this request is submitted via email, my information is not encrypted and could be vulnerable to privacy breaches.
- Information disclosed to individuals or entities not affiliated with a healthcare provider or health plan may not be protected under federal privacy regulations and could be further shared by the recipient.

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

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Records from year(s): _____

Send to:

☐ Check here if records should be sent to the patient at the address listed above.

Name of Representative or Agency: _____

Recipient's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Terms: Unless I expressly limit it in writing, this authorization includes all aspects of testing and/or treatment related to sexually transmitted diseases, HIV/AIDS, alcohol or drug use, mental health conditions, and 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 _____