SOUTH SOUND WOMEN'S CENTER

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REQUEST FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ Birth Date: _____

Former Name(s): _____ SSN #: Call if needed

Obtain Records From:

_____
(Clinic or Physician's Name)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Telephone Number) (Fax Number)

Release Records To:

_____
(Clinic or Physician's Name)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Telephone Number) (Fax Number)

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- ☐ All Health Care Information
- ☐ All MEDICAL RECORDS
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Pap Reports
- ☐ Mammograms
- ☐ Other _____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

_____ _____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Witness: _____ _____
Printed name Signature

NOTE TO THE PROVIDER RECEIVING THESE RECORDS: This information has been disclosed to you from patient records whose confidentiality is protected by state and federal law. State law prohibits you from making further disclosure without the specific written consent of the person to whom it pertains or as otherwise permitted by state law.

NOTE TO PATIENT: We need 48 hours notice for copies of medical records plus there is a required prepaid fee due before release of your medical records. Effective July 1, 2015 Washington State law (WAC 246-08-400) allows that medical record copying fees cannot exceed $1.12 per page for the first 30 pages, then $.84 per page thereafter. A clerical searching and handling fee of $25.00 may apply. A reasonable, cost-based fee can be charged for duplicating X-rays. If a physician needs to personally edit the medical records a basic office visit fee will be charged.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED