PATIENT REQUEST TO VIEW OR COPY MEDICAL RECORDS (Please Print)

PATIENT INFORMATION				
Patient's last name:	First:	Middle Initial:	Birth date:	Sex : ☐M ☐ F
Street address:			Social Security:	
City:	State:	ZIP Code:	Home phone :	Cell phone :

I WANT TO VIEW MY HEATLH INFORMATION RECORDS (*CHECK ALL THAT APPLY*)		
☐ All Health Information in my medical records	☐ Health Information relating only to the following treatment or condition:	☐ Health Information only for the following Dates:

I REQUST A COPY OF MY HEATLH INFORMATION RECORDS (*CHECK ALL THAT APPLY*)		
☐ All Health Information in my medical records	☐ Health Information relating only to the following treatment or condition:	☐ Health Information only for the following Dates:

DELIVERY OF COPIES OF HEALTH INFORMATION RECORDS	
☐ Mail to the address above ☐ I will pick them up	☐ Mail to the following address: ____

FEES FOR COPIES (*PLEASE INITIAL BELOW*)	
__________ I understand that I may be charged a fee for copies of my health information records. Washington State law sets a limit on how much can be charged for these records (WAC 246-08-400). Currently, the fee for copies of records will be:	
$_____ per page for the first 30 pages / $_____ for all other pages	Additional Charges (subject to HIPAA):

I understand that I have the legal right, with certain limitations, to either view or obtain copies of my health information, or that of my minor child whose treatment I authorized. Rights are also granted to the guardian or other authorized person. In some instances, only the minor child may be permitted to view or obtain copies of health information.

I also understand that when deemed advisable by the health care practitioner this right may be denied or limited.

If my access to information is denied or limited, I will be advised of my options.

Patient/Authorized signature:	**Date:**
If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:	

FOR OFFICE USE ONLY	
Date Received:	Date Viewed/Copied:
Name and Title of Person who fulfilled this Request:	
Signature of Person who fulfilled this Request:	

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