3600

SWEDISH

Patient Identification Sticker

PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

In some areas, Swedish and affiliates may store patient clinic records separately from patient hospital records. We would be glad to fax a copy of this form to other facilities upon request.

Please submit this form to one of these locations, depending on where you received care:

Swedish Medical Center	**Swedish Medical Group**
Release of Information	
747 Broadway	Phone: (206) 320-3025
Seattle, WA 98122	Fax: 478-238-9436
Phone: (206) 320-3850	Email: smgroi-wa@cioxhealth.com
Fax: (206) 320-2626	

Important: Swedish and affiliates no longer print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient records that are more than a few years old. The records you are requesting may include your social security number. Fees may be associated with this request.

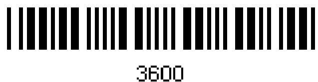
The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Swedish Health Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

ATTENTION: If you speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (Swedish Edmonds (888) 311-9178) (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 311-9127 (Swedish Edmonds (888) 311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 **(888) 311-9127 (Swedish Edmonds (888) 311-9178) (TTY: 711**



PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

Patient Identification Stick

Patient's Name: ____________________

Date of Birth: ____________________

Prior Name(s) Used: ____________________

Patient's Address: ____________________

City: ____________ **State:** ________ **Zip:** ________

Phone: ____________ **Email:** ____________

Please disclose my records to: **Myself**

or the following recipient

Recipient Name: ____________________

Address: ____________________

City: ____________ **State:** ________ **Zip Code:** ________

Fax: ____________ **Email:** ____________

Please send my records via:

MyChart **Email** **Disc**

Fax **Paper**

Form SMC 214-LARGE

I am requesting records from the following Facility(s):	
Hospital(s)/Provider Name	**Clinic(s)/Provider Name**

For the range of dates from:

____________________ **to:** ____________________

Information to be disclosed:

- History & Physical
- Discharge Summary
- Operative Report
- Emergency Dept Report
- Diagnostic Report
- Progress Notes
- Last 2 years only
- Other (specify): ____________________

Fees may be associated with this request. Some records are unavailable to receive via MyChart.

Patient Signature:
(Print form and sign by hand) ______________________________

Date: ____________________

Patient Representative: ______________________________

Representative Signature: ______________________________

Relationship to Patient: ______________________________

Date: ____________________