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 Seattle, WA 98122 Phone: (206) 320-3850 Fax: (206) 320-2626	Phone: (206) 320-3025 Fax: 425-454-2935 Email: smgroi-wa@cioxhealth.com

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**

3600

SWEDISH

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**

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
- ☐ Operative Report
- ☐ Diagnostic Report
- ☐ Last 2 years only
- ☐ Discharge Summary
- ☐ Emergency Dept Report
- ☐ Progress Notes
- ☐ 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: _____

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