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.**

**You may attach an additional page if more room is needed than provided on the request form.**

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

| **Swedish Medical Center** | **Swedish Medical Group** |
|---|---|
| Release of Information<br>747 Broadway<br>Seattle, WA 98122<br>Phone: (206) 320-3850<br>Fax: (206) 320-2626 | Centralized Services Department<br>800 5th Avenue, Suite 800<br>Seattle, WA 98104<br>Phone: (206) 320-3025<br>Fax: 425-454-2935 |

**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).**

3600

SWEDISH

# PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

Patient Identification Stick

**Last Name:** _____ **First:** _____

**Middle:** _____

**Date of Birth:** _____

**Other Name(s) Used:** _____

**Current Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____

**Prior Address-If moved within last 2 yrs.**

**City:** _____ **State:** _____ **Zip:** _____

**Send my records via:**

☐ **Paper** ☐ **Disc** ☐ **MyChart** ☐ **Email:** _____

**Recipient Name:** _____

| | |
|---|---|
| **Fax Number:** | |
| **Recipient Address:** | |

**I am requesting records from the following Facility(s):**

| Hospital(s)/Provider Name | Clinic(s)/Provider Name |
|---|---|
| | |
| | |

**For the range of dates from:**

_____ **to:** _____

☐ **Pertinent Packet:**
- **History & Operative Report**
- **Diagnostic Reports**
- **Discharge Summary**
- **ED Report**
- **Office Visit Notes**

☐ **CD of Diagnostic Film (Please Provide Date/Time):** _____

☐ **Entire Record**

☐ **Other (Specify):** _____

**Patient/Personal Representative:**

**Sign Here:** _____ **Date:** _____

**(Print and sign here)**

**If Personal Representative:**

**Print Name:** _____

**Description of Authority:** _____

**Internal Use Only**

**Date**

**Rec'd**

**ID Verified By** _____

**Implemented: February 2014** **Revised: October 2017**

□