Federal Way Women's Health Care

Request for Release of Medical Records
32114 1st Ave S Suite 203. Federal Way, WA 98003
Phone: 253 838 0219. Fax: 253 838 3449 or 253 838 0077

Please Allow 15 Working Days for Copying and Preparing Records

Patient Full Name:	Date of Birth:	Phone Number:

I hereby request and authorize you to furnish all the requested medical information:

Records From:

_____
Provider or Group Name

_____
Mailing Address

_____
City, State, Zip Code

Records To:

_____
Provider or Group Name

_____
Mailing Address

_____
City, State, Zip Code

What kind of information do you want disclosed?

_____ Information from the most recent 2 years of visit

_____ Information from date (YOU MUST INDICATE DATES): _____ to date: _____

_____ Specific Information (Please Specify): _____

_____ Radiology

Why are you asking for this information to be released? (Circle)

Attorney Insurance Doctor Medical Leave Personal Other _____

Time period of records that I would like to be released is:

All Dates From _____to_____

Acknowledgement of Understanding:

- I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS), or other sexually transmitted diseases, drug and/or alcohol use, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be in effect on the date notified except to the extent action has already been taken.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that Federal Way Women's Health Care cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release Federal Way Women's Health Care and its staff from all legal responsibility that may arise from the release of medical information hereby authorized.

Patient Signature:_____Date:_____

Parent or Guardian:_____Date:_____

CONSENT OF MINOR AGED 14-17:

If the patient is 14 years or older, only the patient may authorize the disclosure of information relating to contraception, pregnancy termination, sterilization, STD's, mental health conditions, alcohol or drug abuse. I understand that my signature authorizes the release of this information.

Authorization is valid for one (1) year ***A photo-static copy of this from shall be considered as effective as the original***