3600

SWEDISH

Patient Identification Sticker

PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

In some areas, Swedish Health Services 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	
747 Broadway, Seattle, WA 98122	Phone: (206) 320-3025
Phone: (206) 320-3850	Fax: 478-238-9436
Fax: (206) 320-2626	Email: smgroi-wa@cioxhealth.com
Email: ROI@swedish.org	

Fees may be associated with this request.

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.

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 do not 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 Identification Sticker

PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

Patient's Name: _____ DOB: _____

Prior Name(s) Used: _____ Phone: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Email: _____

Please disclose my records to: Myself at the address above ☐ or the following recipient ☐

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Please send my records via: ☐ MyChart ☐ Email ☐ Disc ☐ Paper ☐ Fax

I am requesting information from the following facility(s):

List Hospital(s) or Provider Name(s)	AND/OR	List Clinic(s) or Provider Name(s)

For the range of dates from: _____ to: _____

Information to be disclosed:

- ☐ History & Physical
- ☐ Operative Report
- ☐ Diagnostic Report (lab, x-ray, EKG, etc.)
- ☐ Other (specify): _____
- ☐ Discharge Summary
- ☐ Emergency Department Report
- ☐ Progress Notes
- ☐ Last 2 years only

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

Patient Signature: _____ Date: _____

(Print form and sign by hand)

Representative Name: _____ Date: _____

Representative Signature: _____ Relation to Patient: _____

(Print form and sign by hand. Please include supporting documentation.)

1ROI