OVERLAKE MEDICAL CENTER & CLINICS
MultiCare

Health Information Management **Phone: 425-688-5643**
Fax: 425-467-3343

Patient Access Request for Health Information

Must be Completed Fully to Process

1. Patient Information: (Please print)

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

2. Records to be Disclosed: *Note that records may include information related to mental health, treatment of alcohol or drug abuse, sexual transmitted disease, AIDS/HIV diagnosis report, reproductive health care services and gender-affirming treatment.

[ ] Hospital visit notes	[ ] Reports of imaging (x-ray) or cardiology
[ ] Pertinent record (ED notes, encounter notes, imaging, lab, cardiac reports, pathology, surgical info)	[ ] Images of x-rays or cardiology (contact film library at 425-688-5564)
[ ] Clinic records (include name of clinic and/or provider)	[ ] Immunization records
[ ] Emergency department records	[ ] Billing records
[ ] Laboratory results	[ ] Other

3. Dates of Service for Records to Be Disclosed:

☐ All Dates **OR** ☐ From: _____ (Start Date) To: _____ (End Date)

4. Recipient Information:

Recipient: _____

Address: _____

State, Zip: _____

Phone: _____ Fax: _____

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5. Format for Record Delivery

[ ] Upload the information to MyChart secure portal (must have a current MyChart account) (No Fee)
[ ] Mail paper copy to the address listed above. (Fees may apply)
[ ] Fax paper copy to the provider fax number listed above. (No Fee)
[ ] Copy the information to CD and mail to the address listed above. (Fees may apply)
[ ] Email the information via secure email to my email address listed above. (Fees may apply)
[ ] Email the images via PowerShare to my email address listed above. (No Fee)
[ ] Other _____

6. Signature and Consent

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the below)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Executor of Estate*
*Please provide a copy of the legal documentation.

This authorization form can be submitted to the HIM department by mail or by fax:

Address: 1035 116th Ave NE, Bellevue, WA 98004 / Phone: 425-688-5643 / Fax: 425-467-3343

PLACE PATIENT LABEL HERE