OVERLAKE MEDICAL CENTER & CLINICS

Clinic Medical Records **Fax: 425-233-6286**
Hospital Medical Records **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: _____

Phone:_____ Email:_____

2. What records do you want? *Note that records may include information related to mental health, communicable disease, and treatment of alcohol or drug abuse.*

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

3. Dates of Service: From:_____ To: _____

4. How would you like your records delivered?

[ ] Copy the information to CD and mail to my home address listed above (Fees apply)
[ ] Mail the paper information to my home address listed above (Fees apply)
[ ] Upload the information to my MyChart secure portal (must have a current MyChart account) (No fee)
[ ] Other _____

5. Where do you want the information sent?

Requestor signing this form is responsible for accuracy of recipient's name/address/fax/phone.

Recipient:_____

Address: _____

State, Zip: _____

Phone:_____ Fax:_____

There may be fees for producing records. See details at overlakehospital.org/visit/medical-records.

_____

6. Printed Name of Legal Representative if patient is not capable of signing

If not signed by patient, identity relationship to patient. If Legal Representative or other, provide documentation establishing authority such as Power of Attorney.

_____ _____ _____

7. Signature of Patient or Legal Representative **8. Date** **9. Relation to Patient**

Patient Access Request for Health Information
Form A0149D (Rev. 6/2021)
7004

For internal use only _____
Medical record number _____
Date rcv'd _____
Employee initials _____