Date:

**Dear Release of Information (ROI) Service Area Staff:**

**Attached is a copy of the request for** **Additional Privacy Protections, Restrictions, or Alternative Communications.**

Patient Name: Medical Record Number:

This request was recently received at the following UW Medicine entity:

* Check to see if this patient has been treated at your entity and take appropriate steps to accommodate   
  this request in your Electronic Medical Record (EMR).
* If you have questions, please contact the Health Information Management (HIM) office that originated this coordination and action form (see contact information below).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Primary Recipient, Please Check Box for Applicable Entities** | **UW Medicine Entity** | Address | **Phone Number** | Fax Number | **Secondary Entities, Please Enter Number of Pages/Copies Processed** |
|  | **Harborview Medical Center & Clinics**  **University of Washington Medical Center & Clinics**  **UW Neighborhood Clinics (UWNC)**  **Hall Health Center** | 325 9th Ave  Box 359738  Seattle, WA 98104 | 206.744.9000 | 206.744.9997 |  |
|  | **Northwest Hospital & Medical Center** | 1550 N. 115th St.,  Mail Stop D-129  Seattle, WA 98133 | 206.668.1616 | 206.668.1920 |  |
|  | **Valley Medical Center & Clinics** | Release of Information  400 S. 43rd Street  Box 50010  Renton, WA 98058 | 425.251.5159 | 425.656.4026 |  |

**If you have any questions please contact this Health Information Management/ROI Service Areas (Medical Records Department) at:**

**Contact Person: Phone #:**