

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form is to request access to my protected health information located at the following UW Medicine entities*: _____

Please write in above only the entities where you have been a patient and you intend to request access

** University of Washington Medical Center & Clinics, Harborview Medical Center & Clinics; UW Medicine Neighborhood Clinics; University of Washington Sports Medicine Clinic; UW Physicians Eastside Specialty Center; Hall Health Primary Care Center; or University of Washington Physicians (Billing records only).*

You will only receive information from the entity or entities that have records.

UW Medicine may impose a reasonable per page copying fee.

to provide information regarding:

NAME OF PATIENT _____ BIRTHDATE _____
 for the time period beginning _____ DATE _____ and ending _____ DATE _____

for the following health care information:

PLEASE CHECK ALL APPROPRIATE BOXES

- | | | |
|---|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> RADIOLOGY RECORDS |
| <input type="checkbox"/> SUMMARY OF MEDICAL HISTORY / TREATMENT | <input type="checkbox"/> CONSULTATION | <input type="checkbox"/> RADIOLOGY FILMS |
| <input type="checkbox"/> LABORATORY / DIAGNOSTIC TESTS | <input type="checkbox"/> EKG REPORT | <input type="checkbox"/> EEG REPORT |
| <input type="checkbox"/> PSYCHOLOGICAL TESTING | <input type="checkbox"/> PATHOLOGY REPORT(S) | <input type="checkbox"/> OPERATIVE REPORT |
| <input type="checkbox"/> PATHOLOGY SPECIMEN(S) / SLIDE(S) | | |
| <input type="checkbox"/> OTHER (Please Specify): _____ | | |

PLEASE SELECT METHOD OF DELIVERY

- Please mail copies of requested information to my address:
 (Please print address clearly and include zip code)

STREET ADDRESS _____ STATE _____ ZIP CODE _____

- Please contact me to make an appointment to inspect this requested information:
 (Please print contact information clearly and include preferred method of contact telephone or email)

- Please provide copies of requested information for me to pick-up.

The requested information will be ready for me to pick-up on: _____ DATE _____

Requested information will be held for pick-up for a maximum of 30-days.

DATE	SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)
WITNESS	IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF THEIR AUTHORITY

PT.NO

NAME

DOB

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION



U1870

UH1870 REV MAR 03

WHITE – MEDICAL RECORD
 CANARY - VARIABLE

CONSENT - GRAY