

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.

<input type="checkbox"/> Hospital visit notes	<input type="checkbox"/> Images of x-rays or cardiology on CD (contact film library at 425-688-5564)
<input type="checkbox"/> Pertinent record (ED notes, encounter notes, imaging, lab, cardiac reports, pathology, surgical info)	<input type="checkbox"/> Immunization records
<input type="checkbox"/> Clinic records (include name of clinic and/or provider)	<input type="checkbox"/> Billing records
<input type="checkbox"/> Emergency department records	<input type="checkbox"/> Substance Use Disorder (SUD)Records (Protected under 42 CFR Part 2)
<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Psychotherapy notes
<input type="checkbox"/> Reports of imaging (x-ray) or cardiology	<input type="checkbox"/> 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: _____

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 requested diagnostic images—such as X-rays, ultrasounds, or other imaging—through 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

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Form A0149D  (Rev. 9/2026)
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PLACE PATIENT LABEL HERE