OVERLAKE
MEDICAL CENTER AND 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 (xray) or cardiology
[ ] Emergency Department records	[ ] Immunization 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 xrays 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 One Chart secure portal (must have a current One Chart account) (No fee)

[___] I will pick up the records in person (Government Issued Photo ID will be required) (Fees apply)

[___] 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: ____

City, State, Zip:____

Phone:_______________________________Fax:______________________

There may be fees for producing records. See details at www.overlakehospital.org/patients-and-families

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

If not signed by patient, identify 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 *7004* (Rev. 6/18)

For internal use only
Medical record number___________________
Date rcv'd ____________________________
Employee initials_______________________