West Seattle Foot & Ankle Clinic

Medical Records Request & Transfer Form

Instructions: To have records transferred from West Seattle Foot & Ankle Clinic, complete and sign this form. Then:

1. Upload it to your patient portal at www.wsfac.com or
2. Fax it to (206) 937-4778 or
3. Mail or deliver it to the clinic at 4520 42nd Ave. SW, Suite 34, Seattle, WA 98116

Patient Last Name:	Patient First Name:			MI:
Patient Date of Birth:	○ Male ○ Female			
Patient Address:	City:	State:	Zip:	
Patient Phone:	Email:			

○ **I hereby request and authorize West Seattle Foot & Ankle Clinic provide me a copy of my medical records.**

○ **I hereby request and authorize West Seattle Foot & Ankle Clinic to release my medical records to a third party:**

Recipient Name:		Type: ○ Provider ○ Third Party	
Recipient Address:	City:	State:	Zip:
Recipient Phone:	Fax:	Email:	

This authorization allows for disclosure of the following record types for the dates___(MM/YY) to___(MM/YY):

○ Chart Notes ○ Operative Reports ○ Laboratory Results ○ X-Rays ○ Imaging Reports

○ All Records ○ Other specified information: ________________________________

The purpose of this request is for:

○ Transfer of Care ○ Continuing Care ○ Insurance ○ Legal ○ Personal Use ○ Other (please specify):

Check the box to elect the method and delivery for records delivered from West Seattle Foot & Ankle Clinic.
Please note that all DICOM x-ray images will be made available on CD and must be mailed or picked up at the clinic.

Recipient Type	Delivery Method (Cost)
Patient	○ WEST SEATTLE FOOT & ANKLE CLINIC PATIENT PORTAL ○ MAIL ($10 processing fee + postage) ○ PATIENT PICK UP ($10 processing fee) ○ FAX ($10 processing fee)
Provider	○ MAIL (no cost) ○ FAX (no cost)
Third Party	○ MAIL ($28 Processing Fee + $1.24/page up to 30 pages and 0.94/page thereafter + Postage) ○ FAX ($28 Processing Fee + $1.24/page up to 30 pages and 0.94/page thereafter)

All fees assessed are in accordance with RCW 70.02.010(38) and WAC 246-08-400

Disclosure of Sensitive Information: *I understand that my health record may contain sensitive information. This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental services and treatment for alcohol or drug abuse. By initialing here_______, I choose to* ***EXCLUDE*** *the above types of information from this disclosure.*

Terms and Conditions: *I have the right to revoke this Authorization, in writing, at any time by notifying West Seattle Foot & Ankle Clinic. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization. I have the right not to sign this Authorization. West Seattle Foot & Ankle Clinic will not condition treatments, payment of services or enrollment or eligibility for benefit on whether I sign this Authorization. I understand that submitting this Authorization to West Seattle Foot & Ankle Clinic will not terminate the patient's relationship to the practice. If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is potential for this information to be subject to re-discloser and no longer be protected by these laws. I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization. I understand there may be costs associated with the transfer of information, depending on the method of transfer I choose, and I am responsible for the cost. This Authorization expires one (1) year after the date of the signature unless otherwise specified here_____________________________.*

Signature:____**Date:** ____________________________

Printed Name: ____

Signature by: ◯ Patient ◯ Parent ◯ Legal Guardian

Dr. Matthew A. LaBella **Dr. Ryan J. Schwanke**

West Seattle Foot & Ankle Clinic
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