West Seattle
Foot & Ankle Clinic

Medical Records Request Form

I hereby request and authorize my medical records to be released to West Seattle Foot & Ankle Clinic from:

Provider Name:			
Provider Address:	City:	State:	Zip:
Provider Phone:	Fax:		

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

This authorization allows for disclosure of the following record types for the dates _____(MM/YY) to _____ (MM/YY):

◯ All Records	◯ Progress Notes	◯ Laboratory Results	◯ X-Rays
◯ Operative Reports	◯ Hospital Records	◯ Imaging Reports	◯ Other specified information:

Disclosure of Sensitive Information: *I understand that my health record may contain sensitive information relating to patient's conditions. 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 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. This Authorization expires one (1) year after the date of the signature unless otherwise specified here _____.*

Send records to: **West Seattle Foot & Ankle Clinic** 4520 42nd Ave. SW, Suite 34 Seattle, WA 98116 Fax: (206) 937-4778	**Signature: _____ Date: _____** **Printed Name: _____** **Signature by:** ◯ Patient ◯ Parent ◯ Legal Guardian