Valley|Cities

REQUEST TO OBTAIN
MEDICAL RECORDS

CLIENT OR LEGAL REPRESENTATIVE
REQUEST TO OBTAIN MEDICAL RECORDS

Return to: MEDICAL RECORDS
33405 8TH Ave S, Suite 200
Federal Way, WA 98003

☎ (206) 408-5227
FAX (253) 835-9976

CLIENT'S FULL LEGAL NAME _____ CLIENT'S DATE OF BIRTH _____

CLIENT'S SOCIAL SECURITY NUMBER - IF AVAILABLE _____ CLIENT'S PHONE NUMBER _____

I HEREBY REQUEST A COPY OF MY MEDICAL RECORDS FROM VALLEY CITIES COUNSELING AND CONSULTATION.

Date Range of Requested Records: ☐ **All Record Dates** **OR** **FROM:** _____ **TO:** _____

Types of Records Requested: ☐ All Clinical Records ☐ All Financial/Billing Records

Or only items checked:

- ☐ Assessment(s), Update(s)
- ☐ Crisis Plan
- ☐ Treatment Plan(s)
- ☐ SUD Program Status Reports
- ☐ Discharge Summary(ies)
- ☐ Psychiatric Evaluation
- ☐ Psychiatric or Medical Notes
- ☐ Active Medications
- ☐ Active Problem List (Diagnoses)
- ☐ Laboratory Reports/Results
- ☐ Individual Treatment
- ☐ Group Treatment
- ☐ Family Treatment
- ☐ Peer Services
- ☐ Case Management/Community Support
- ☐ Other (specify):_____

I would like to receive these documents in the following manner: ☐ Electronic PDF ☐ PRINTED ON PAPER

☐ Please mail records to this address:_____
(street address) (city) (state) (zip code)

☐ I will pick up records at the following clinic when they are ready:_____
(clinic location)

☐ I have a client portal account and would like the PDF version attached to my portal so I can download it.

I understand that:

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of records. (RCW 70.02.130 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 7.70.068).
- Any records that contain information regarding mental health are protected by state law (RCW 70.02); drug/alcohol abuse or treatment records are protected under federal confidentiality laws (42 CFR 2); HIV/AIDS or confirmed STD tests or treatment records are protected by state confidentiality laws (RCW 70.24).
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Mental Health information, I must do so in writing. I can revoke a release of Alcohol and Substance Abuse information verbally to my clinician or the program manager. Unless I cancel earlier, this release will expire once I have received the records listed above.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- Once the above information is released to me, the security of the documents/information is solely within my power to control.

CLIENT SIGNATURE _____ RELATIONSHIP TO CLIENT _____

WRITTEN NAME _____ EFFECTIVE DATE FOR RELEASE _____

AUTHORIZED SIGNATURE OF PERSONAL REPRESENTATIVE (IF NOT *SELF/CLIENT) _____

Valley Cities ID# _____