HIV/STD Program Services
Request for Records

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Name of Patient: _____ Patient Date of Birth: ____/____/____

Treatment Location: ☒ HIV/STD Services

If you are not the Patient:

Your Name: _____

Your Relationship to Patient: _____ Identification: _____

What is your authorization to receive the patient's information?

☐ Written patient authorization (attach documentation).
☐ Patient's parent or guardian (attach documentation).
☐ Patient's health care decision maker (attach documentation).
☐ Other: (Please Explain) _____

Information Requested: (check what you are requesting)

☐ Discuss my HIV status/results.
☐ Discuss my GC infection.
☐ Discuss my CT infection.
☐ Discuss my Syphilis infection.
☐ Discuss/disclose PrEP labs.
☐ Disclose Hep C labs.
☐ Copy of patient's office visits (specify dates): _____ to _____
☐ Copy of patient's treatment record from (specify dates): _____ to _____
☐ Other (Please Explain): _____

Charges for Information:

I understand I may be charged for the copies as follows:

- Medical Records Retrieval and File Copy rates:
  - **$26** Retrieval fee plus applicable photocopy charges.
  - **$1.17** per page photocopy charge for the first thirty pages.
  - **$0.88** per page photocopy charge for all other pages.

- Billing records will be copied at a charge of **$0.15** per page.

All information mailed will be subject to postage or other delivery fees.

Method of Delivering Information:

☐ Please fax records to TPCHD Confidential Fax at: (253) 649-1358

☐ I will pick up copies of the records at:

☐ HIV/STD Program Services
3629 South D Street
Tacoma, WA 98418

☐ Please mail the records to me at: _____

_____

_____

I am authorized to receive copies of the medical and billing records for:
_____, (insert patient's name)
I understand that I may be charged as set forth above for the copies of records I have requested and for postage, if needed, and I agree to pay the total charges prior to my receiving the copies.

_____
Signature

_____
Print Name

_____
Date

Notice Prohibiting Redisclosure:

If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32.

In additon, disclosure of the transmitted records or information to anyone is prohibited by state law.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **not** sufficient for this purpose.