Treatment Services
Request for Records

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

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

Date(s) Patient was in Treatment: _____

Treatment Location: ☒ Treatment 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).
- ☐ Patient is deceased and you are the personal representative of patient's estate (attach documentation).
- ☐ Other: (Please Explain) _____

Information Requested: (check what you are requesting)

- ☐ Copy of patient's admit letter.
- ☐ Copy of patient's treatment plan.
- ☐ Copy of patient's completion certificate.
- ☐ Copy of patient's compliance reports from (specify dates): _____ to _____
- ☐ Copy of patient's treatment record from (specify dates): _____ to _____
- ☐ Copy of the complete intake.
- ☐ Copy of the complete discharge summary.
- ☐ Copy of the billing record(s) from (specify dates): _____ to _____
- ☐ Letter with a summary of billing records.
- ☐ Letter with a summary of the dates the patient was in treatment.
- ☐ 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:

☐ I will pick up copies of the records at:

☐ Treatment Services
3629 South D Street
Tacoma, WA 98418

☐ Please mail the records to me at: _____
_____
_____

☐ I will call the Records Coordinator to arrange a time to review my original records on site at:

☐ Treatment Services
3629 South D Street
Tacoma, WA 98418

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:
This information has been disclosed to you from records protected by Federal Confidentiality (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. In the event you receive a request for any or all of the enclosed records or information, that request must be referred to **THIS AGENCY.**

IN ADDITION, 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.