Medical Records Request

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Patient name

Patient date of birth

Other patient identifiers

If you are not the patient:

Your name

Your relationship to the patient

What gives you authority to receive the patient's records?

- ❑ Written authorization from patient—attach documentation
- ❑ Patient's parent or guardian—attach documentation
- ❑ Patient's healthcare decision-maker or medical power of attorney—attach documentation
- ❑ Representative of patient's estate—attach documentation
- ❑ Other _____

VALIDATION

Requested records

- ❑ Immunization records
- ❑ COVID-19 immunization records
- ❑ Medical records for visits dated _____
- ❑ Billing records for visits dated _____
- ❑ Summary medical records (patient history and nurse progress notes) for visits dated _____
- ❑ Summary medical records (patient billing statement coverage page) for visits dated _____
- ❑ Other _____

Charges

I understand the Health Department may charge me as shown below.

- Medical records retrieval and copy rates:
  - Retrieval fee $26
  - Plus, per page photocopy charge for first 30 pages $1.17
  - Plus, per page photocopy charge for all other pages $0.88
- Billing records will be copies at a charge of ..... $0.15 per page
- Official copy of immunization record without vaccine administration $10
- Certification letter of tuberculosis treatment for employment $10
- Record of tuberculosis PPD test results $10
- Hepatitis screening results letter $5
- Printout of immunization record without vaccine administration $5
- Non-sufficient funds (NSF) check charge $35

All mailed information is subject to postage or other delivery fees.

Record delivery

❑ I will pick up the record copies at the Health Department.

❑ Mail the record copies to me.

Address _____

❑ Securely email the record copies to me.

Email address_____

❑ Call me to arrange a time to review the original records in person at the Health Department.

Phone number_____

❑ I will call to arrange a time to review the original records in person at the Health Department.

Certification

I am authorized to receive medical and billing records for _____.
I understand the Health Department may charge me as shown above. I agree to pay the total charges before receiving the records.

_____	_____	_____
Signature	Printed name	Date