CEDAR RIVER CLINICS

☐ TACOMA: 1401-A Martin Luther King Jr. Way · Tacoma, WA 98405 · 253.473.6031
☐ RENTON: 263 Rainier Ave S. #200 · Renton, WA 98057 · 425.255.0471

Appointments: 800-572-4223
web: www.CedarRiverClinics.org

RECORDS RELEASE

PLEASE COMPLETE FORM AND SIGN AND DATE WHERE INDICATED.

Client Name:_____

Birth date: _____ Soc Sec #: _____

I request and authorize Cedar River Clinics to release healthcare information of the client named above to:

Name: _____

Mailing Address_____
STREET CITY STATE ZIP

Contact Phone #: _____ Fax #: _____

Email Address: _____

Method of Delivery: ❑ Pick Up at Clinic ❑ Faxed ❑ Mailed Uncertified ❑ Mailed Certified** ❑ Unsecured Email
**Current USPS Rate Charged Prior to Mailing

I understand my medical records may contain information regarding sexually transmitted diseases, including HIV/AIDS. Release of this information is voluntary and is protected by State Law. I authorize you to release the following information to the physician/clinic/individual indicated above:

- ❑ My **COMPLETE** medical record, including current and past history, testing, and/or treatment for sexually transmitted diseases, **INCLUDING** information pertaining to HIV testing and AIDS.
- ❑ My **COMPLETE** medical record, including current and past history, testing, and/or treatment for sexually transmitted diseases, **EXCEPT** for information pertaining to HIV testing and AIDS.
- ❑ My **CURRENT** medical record, **BUT NOT** information relating to my past history, testing and/or treatment for sexually transmitted diseases or information pertaining to HIV testing and AIDS.
- ❑ My **CURRENT** medical record, **INCLUDING** information relating to testing and/or treatment for sexually transmitted diseases, or information pertaining to HIV testing and AIDS.
- ❑ My ultrasound record only.
- ❑ Other (please specify): _____

_____

Client Signature: _____ Date: _____

FOR CLINIC USE ONLY

- ❑ Entered In PHI Log
- ❑ Records sent: ❑ Mailed ❑ Faxed ❑ Hand delivered ❑ Emailed

Date sent: _____ By: _____

- ❑ Records NOT sent (explain): _____

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REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

This form is used by the client to request an opportunity to examine or copy Protected Health Information in the possession of Cedar River Clinics dba Cedar River Clinic-Renton, Cedar River Clinics-Tacoma, and Cedar River Clinics-Yakima.

Information Requested

Please describe the information that you would like to examine or copy:

_____

_____

_____

_____

Review Procedures

Your request to inspect or copy your Protected Health Information will be reviewed by the FWHC Privacy Officer, who will determine if the information requested can be made available to you. We may be legally prohibited from making certain information available to clients or client representatives, including:

- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information that was obtained under a promise of confidentiality

Within the limitations of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect your records within 30 days of your request, or provide you with a written explanation of any restrictions on the information that we can provide you.

If we deny your request, in whole or in part, you may request that we review that decision.

Print Client Name

Signature Date

Signature of Client Representative

Relationship to Client