

□TACOMA: 1401-A Martin Luther King Jr. Way · Tacoma, WA 98405 □RENTON: 263 Rainier Ave S. #200 · Renton, WA 98057 □SEATTLE: 509 Olive Way, Ste. 1454 · Seattle, WA 98101

Phone: 800-572-4223

web: www.CedarRiverClinics.org

RECORDS RELEASE FORM PLEASE COMPLETE FORM AND SIGN AND DATE WHERE INDICATED.

Client Name:				
Pervious Names Used:	Estimate Year of Last	: Service:		
Birth date:	Soc Sec #:			
Client Contact Phone Number/Ema	ail Address: Check if Ever Seen at Auara Medical Serv	vices (AMS) Clinic		
I request and authorize Cedar Riv	er Clinics to release healthcare informa	ation of the clie	ent named ab	ove to:
Name:				
Mailing Address	CITY	STATE	ZIP	
	Fax #:			
Email Address:				
I understand my medical records may of this information is voluntary and is physician/clinic/individual indicated at the My COMPLETE medical My COMPLETE medical INCLUDING in EXCEPT for in Lab Results Only	nic Faxed Mailed Uncertified Mai **Current USPS Rate Charged Prior to ay contain information regarding sexually to se protected by State Law. I authorize you above: all record, including current and past history information pertaining to HIV testing and AIDS; and/ information pertaining to HIV testing and AIDS; and/	ransmitted dise to release the y for treatment for se for treatment for se	ases, includin following information in the state of the	g HIV/AIDS. Release mation to the d diseases d diseases
	information pertaining to HIV testing and AIDS; and			
☐ Medical Records from☐ Other (please specify):	Date Ranges:to		·	
Client Signature: Your request to inspect or copy your Protected Health Inform from making certain information available to clients or client to medical research in which you have agreed to participate. Within the limitations of the law, we will make every effort to a	ge for you to inspect your records within 30 days of your request, or pro	formation that federal or st another person -Informatio	ate laws prevent us fror on that was obtained und	m disclosing -Information that is related der a promise of confidentiality.
FOR CLINIC USE ONLY □ Entered In PHI Log □ Re-Verified Iden □ Records sent: □ Mailed □ Faxed □ □ Records NOT sent (explain):	tifiers Match Hand delivered □ Emailed Date sent:	By:		