Request for Access to Health Information

Note: To authorize disclosure of your health information to another individual or agency, you must fill out the Authorization to Disclose Health Information Form or write a letter.

Last Name:	First:		M.I.:
Other Name(s) Used:		Date of Birth:	
Phone #:	Fax #:		
Address:	City:	State:	Zip:

I would like to:

☐ Inspect my health information ☐ Receive a copy of my health information

I request that my health records be sent by:

☐ Mail (address above) ☐ Fax (fax number above) ☐ Call me to pick up (phone number above)

☐ Other: _____

I am requesting the following records:

☐ Immunization record ☐ Treatment Records ☐ Diagnosis Records

☐ Care Plan ☐ Case/Progress Notes ☐ Prescriptions

☐ Tuberculosis Treatment/Testing ☐ STD Records ☐ Entire Record

☐ Other: _____

For these specific dates of service: _____to _____

_____ _____

Client signature (Parent or Legal Representative, if applicable) Date

_____ _____

Print Name Relationship/Authority

**Attach legal documentation if you are the legal guardian or have medical power of attorney*

Spokane Regional Health District assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. To file a complaint or to request more information, reasonable accommodations, or language translations, contact 509.324.1501 or visit srhd.org.

Internal Use Only:					
Date received:		Received by:			
Date forwarded:		Request forwarded to:		Division:	
☐ Inspection of Health Information		☐ Copy of Health Information			
Inspection scheduled on:		Copies provided by:			
Inspection completed on:		Copies provided on:			