The Steven A. Cohen Military Family Clinic at Valley Cities

REQUEST TO OBTAIN SELF MEDICAL RECORDS

****Records requests can take up to 15 business days for processing****

Return To: ***MEDICAL RECORDS*** | **Address:** 6103 Mount Tacoma Drive, Lakewood WA 98499 | **Phone:** 253-215-7070 | **Fax:** 253-584-1923

CLIENT'S FULL LEGAL NAME:

_____

CLIENT'S DATE OF BIRTH:

_____

CONTACT PHONE NUMBER:

_____

I HEREBY REQUEST A COPY OF MY MEDICAL RECORDS FROM THE COHEN CLINIC AT VALLEY CITIES.

☐ **All Mental Health Records**

☐ **All Mental Health Financial/Billing Records**

Or

Specific Dates of Service:

From_____ To_____

(*Most recent 1 year of records is the default if no dates are selected.*)

If ***ALL RECORDS*** are ***NOT*** needed, ***ONLY*** check items below:

☐ Assessment(s)/Update(s)	☐ Psychiatric Evaluation	☐ Individual Treatment
☐ Crisis Plan	☐ Psychiatric or Medical Notes	☐ Group Treatment
☐ Treatment Plan(s)	☐ Active Medications	☐ Family Treatment
☐ Scheduling/Appointment History	☐ Active Problem List (Diagnoses)	☐ Peer Services
☐ Discharge Summary(s):	☐ Laboratory Reports/Results	☐ Case Management/Community Support

☐ Other (specify): _____

I would like to receive these documents in the following manner:

☐ Electronic PDF ☐ Printed on Paper

_____

☐ ***I consent to receiving my medical records electronically encrypted to my email address:*** _____

IMPORTANT! Encrypted emails allow Cohen Clinic staff to exchange information efficiently for the benefit of our clients. We recognize that during transmission, you may be unable to open encrypted emails. Should this happen, please contact us.

☐ **Please mail the records to this address:**_____

(street address) (city) (state) (zip code)

☐ **I will pick up records at the Cohen Clinic at Valley Cities when they are ready.**

☐ **I have a Phreesia account and would like the PDF version to be attached so I can download it.**

SIGNATURE REQUIRED ON PAGE 2

I understand that:

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of records. (RCW 70.02.130 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 11.125.050).
- This authorization is my consent that allows the Cohen Clinic at Valley Cities to disclose information about my healthcare, mental health, substance use treatment, HIV/AIDS, and sexually transmitted diseases. These records are protected by state and federal law (RCW 70.02, RCW 70.24, 42 CFR Part 2, 45 CFR Parts 160 & 164) and cannot be shared without my written consent, except as permitted by law.
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Mental Health information, I must do so in writing. Unless I cancel earlier, this release will expire once I have received the records listed above.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- Once the above information is released to me, the security of the documents/information is solely within my power to control.

Signature:

Client/ Legal Authority Signature: _____ **Date:** _____

Written Name of Client/Legal Authority: _____

If the authorization is signed by a Legal Authority of the individual, a description of such representative's authority to act for the individual must also be provided.

Description of Legal Authority: _____

Relationship to Client: _____

SIGNATURE REQUIRED ABOVE

******IMPORTANT INFORMATION******

If you need updated records at a later date, a new request (this form) will need to be submitted.

Questions? Call the Cohen Clinic at Valley Cities @ 253-215-7070 (Monday – Thursday 8:30am-5pm, Friday 8:30am-3pm)