



PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

You may attach an additional page if more room is needed than provided on the request form.

If you are requesting records for a deceased patient please contact the Central Release of Information Department to obtain an Affidavit of Surviving Spouse/Next of Kin and further directions.

Please forward this form to:

Kadlec Regional Medical Center

Dept: Release of Information

800 Swift Blvd, Suite 180

Richland, WA 99352

Phone: (509) 942-2017 | Fax: (509) 392-5682

Important: Kadlec no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient records that is more than a few years old. The information you are requesting may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Kadlec does not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 311-9127 (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 (888) 311-9127 (TTY: 711)。



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Patient's Name: _____ DOB: _____

Prior Name(s) Used: _____ Contact Phone: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Email: _____

Please disclose my records to: Myself at the address above or the following recipient

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Please send my records via: MyChart Email Disc Paper Fax

I am requesting information from the following facility(s):

List Hospital(s) or Provider Name(s)	AND/OR	List Clinic(s) or Provider Name(s)

For the range of dates from: _____ to: _____

Information to be disclosed:

- | | |
|---|-----------------------------|
| History & Physical | Discharge Summary |
| Operative Report | Emergency Department Report |
| Diagnostic Report (lab, x-ray, EKG, etc.) | Progress Notes |
| Other (specify): _____ | Last 2 years only |

Fees may be associated with this request. Some records are unavailable to receive via MyChart.

Patient Signature: _____ Date: _____
(Print form and sign by hand)

Representative Name: _____ Date: _____

Representative Signature: _____ Relation to Patient: _____
(Print form and sign by hand. Please include supporting documentation.)