Swedish Radia Imaging Center Edmonds
21700 Highway 99
Edmonds, WA 98026
425-640-4949 425-640-4940 (fax)

Medical Records Request

I, _____, hereby authorize Radia to disclose the health information of:

_____	_____	____ /____ /_____
Name of Patient (please print)	Medical Record Number	Date of Birth

Information to be sent to: ❑ Self OR

Name of recipient: _____

Address: _____

City, State, Zip: _____ Phone: ( )_____

Health Information to be Disclosed:

❑ Radiology Report(s) ❑ Radiology Image(s) ○ on CD OR
○ to Ambra portal/notify by email (email address required) _____

❑ Other (please specify): _____

Exam Type(s): _____

Date(s) of Service: _____

Patient Authorization:

I understand that my records may contain information regarding diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment unless specifically excluded.

Please check only if you do NOT want this information released:

❑ Drug/Alcohol abuse/treatment & diagnosis ❑ Sexually Transmitted Disease
❑ HIV/AIDS diagnosis/treatment testing ❑ Mental health or Psychiatric diagnosis/treatment

Patient Rights:

- Authorizing the disclosure of health information is voluntary. I do not need to sign this for treatment. I may still obtain a copy of my records should I not desire to complete/sign this form.
- I may revoke this authorization at any time in writing to the facility releasing information. I understand that once information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release and distribution that may not be protected by confidentiality laws.
- I can request a copy of this authorization from the representative processing the authorization.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: _____. Exception: If information is released to an employer or financial institution, this authorization is valid for 90 days from the date signed.

Signature: _____ Date: ____ /____ /_____

If other than Patient, indicate relationship to Patient: _____
(Guardian, Authorized Representative: Please provide documentation to confirm authority to sign on behalf of patient)

CD/Films Created By			
Correct Images/Records Verified By			
Delivered to Patient/ID Verified By		Date	
Image upload to Ambra By		Date	