

PROVIDENCE ST. PETER CHEMICAL DEPENDENCY CENTER
 4800 COLLEGE STREET SE, LACEY, WA 98503
 (360) 456-7575/ (800) 332-0465/ FAX (360) 493-5088/ TDD (360) 493-7739

MEDICAL RECORDS REQUEST

IMPORTANT: Requests for records take at least 48 hours to process. Your records can be mailed or picked up. Please indicate your preference:

Please mail

I will pick them up

Client's Full Last Name:

Client's Full First Name:

Client's Full Middle Name:

Client's DOB:

Date of Admission:

Recipient's Name:

Client's Phone Number:

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Recipient's Address:

City, State, & Zip:

Recipient's Phone:

What information do you need from your records?

What purpose do you need these records? (mark all that apply)

Legal _____ Transferring Agencies _____ Medical _____ DOL Requirements _____

I understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it 1) by letter to Providence St. Peter Chemical Dependency Center, Attn: Medical Records, 4800 College Street S.E., Lacey, WA, 98503 or 2) by filling out a revocation form. The form is available from PSPCDC Medical Records Department. Unless revoked earlier, this consent shall expire 90 days from the date of signature, or as otherwise specified here:_____.

I understand my treatment may not be conditioned on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature _____

Date _____

For Medical Records Staff:

Records Mailed on _____ Records at Front Desk for Pick Up Records Not Located