2128

KADLEC REGIONAL MEDICAL CENTER

Patient Identification Sticker

PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

In some areas, Kadlec and affiliates may store patient records separately for hospitals.

We would be glad to fax a copy of this form to other facilities upon request.

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

Please forward this form to the Medical Record Department where you were seen. If you were seen at multiple facilities or are unsure of the appropriate contact information, you may forward the request to:

Attn: Radiology File Room

Kadlec Health System

888 Swift Blvd

Richland, WA 99352

Phone: (509) 942-2647

email: radiologyfileroom@providence.org

Important: Kadlec and affiliates no longer print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient records that are more than a few years old. The records you are requesting may include your social security number. Fees may be associated with this request. Some records are unavailable to receive via MyChart.

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.

***Attention**: If you do not speak english, you have at your disposal free language assistance services. Call 888-311-9127 (Swedish Edmonds 888-311-9178)
***Atención**: Si no hablas inglés, tienes a tu disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711)

Revised: May 2024

2128

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PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET

Patient Identification Sticker

Last Name: First: Middle:

Date of Birth: Other Name(s) Used:

Current Address:

City: State: Zip: Phone:

Prior Address-If moved within last 2 yrs.

City: State: Zip:

Send my records via: ☐ Paper ☐ Disc ☐ Email:

Recipient Name: Fax Number:

Recipient Address:

I am requesting records from the following Facility(s):

Hospital(s)/Provider Name	Clinic(s)/Provider Name

For the range of dates from: to:

☐ Pertinent Packet:
- Diagnostic Reports (US, NM, CT, XR, MRI)
- EKG • ECHO • MAMMOGRAPHY

☐ CD of Diagnostic Film (Please Provide Date/Time): _____

☐ Other (Specify):

☐ OPIC ☐ KRMC Main ☐ Mail

Patient/Personal Representative Sign Here:

_____ Date: _____

(Print and sign here)

If Personal Representative:

Print name:

Description of Authority:

Internal Use Only
Date Rec'd: _____
ID Verified by:
_____

Revised: May 2024