



SOUTHWEST  
WASHINGTON  
MEDICAL CENTER

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## INSTRUCTIONS

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### TO FILL OUT A REQUEST TO TRANSFER YOUR MEDICAL RECORDS

1. **Print out** the blank request form.
2. **Read and fill out the form *completely*.**  
List dates of visits as closely as you can.
3. **Sign and date** the form.
4. **Include a note** with your **name and a phone number** where we can reach you.
5. **Mail or fax** the form to:

Health Information Services  
Southwest Washington Medical Center  
Po Box 1600  
Vancouver, WA 98668

**FAX:** 1-360-514-3362

**PHONE:** 1-360-514-2020-call with questions

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**Please allow five (5) working days to process a request.  
You will be told if there is a charge.**

PATIENT NAME	BIRTHDATE
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**THIS IS TO AUTHORIZE THE RELEASE OF INFORMATION REGARDING THE ABOVE NAMED PATIENT.**

<b>TO</b>	FACILITY / PERSON		
	ADDRESS		
	CITY	STATE	ZIP CODE
	PHONE NUMBER	FAX NUMBER	

<b>FROM</b>	FACILITY/ PERSON <b>SOUTHWEST WASHINGTON MEDICAL CENTER</b>		
	ADDRESS <b>P.O. Box 1600</b>		
	CITY <b>Vancouver,</b>	STATE <b>Washington</b>	ZIP CODE <b>98668</b>
	PHONE NUMBER <b>(360) 514-2020</b>	FAX NUMBER <b>(360) 514-4121</b>	

Information needed for: \_\_\_\_\_

Date(s) of visit(s): \_\_\_\_\_

Information requested: \_\_\_\_\_

*I specifically authorize the release of information pertaining to psychiatric history, drug and/or alcohol abuse, HIV/AIDS and sexually transmitted diseases if such is a part of the medical record.*

**X**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Person / Relationship if other than Patient

*This consent is valid for 90 days from the date of signature. Once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it. This authorization may be revoked in writing. If revoked it would not affect any actions already taken by SWMC based upon this authorization. Revoking this authorization will not affect your ability to receive treatment.*