FamilyCare of Kent

Records Release Authorization

400 W. Gowe St., Suite 400
Kent WA 98032
253.859.CARE (2273)
Fax: 253.850.8894

I authorize and request the release of records

❑ to FamilyCare from:
❑ from FamilyCare to:
❑ between FamilyCare and:

_____
_____
_____
_____

⇐ Fold

Fold ⇒

❑ The complete medical records in their possession concerning my care during the approximate period:

❑ To include any and all information regarding diagnosis and treatment of Psychiatric disorders, Alcoholism, Drug Dependency, Sexually Transmitted Diseases, HIV, and AIDS.

❑ The following parts of my medical record:

- ❑ Summary of Medical History and Treatment
- ❑ Hospital Admission and Discharge Summaries
- ❑ Radiology Reports
- ❑ Other
- ❑ Laboratory Test Reports
- ❑ Operative Reports
- ❑ Radiology Films

Name: _____ Date of Birth: _____

Previous name: _____ Clinic ID#: _____

This authorization will remain in effect for ninety (90) days from the date signed. A photocopy of this release of records may be used instead of the original.

Signature: _____ Date signed: _____
If child, parent or guardian signature

	1st req.	2nd req.	Recv'd	Reviewed	Filed	Sent
Date:						
Staff:						