SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR ACCESS FORM

I hereby request that Sound provide access to health care information regarding the following patient that is maintained by the hospital:

PATIENT NAME:_____

BIRTH DATE:_____ SSN:_____

ADDRESS:_____

TELEPHONE:_____

DESCRIBE THE INFORMATION YOU WOULD LIKE TO ACCESS (Please include dates).

_____

_____

PLEASE CHECK THE METHOD OF ACCESS THAT YOU DESIRE:

- ☐ In-person inspection at our office
- ☐ Copies – Please note that there may be a charge associated with copying and shipping your records. You will be informed of and billed for these charges prior to shipping.
- ☐ Copy of information in electronic format, in the event Sound uses or maintains an electronic health record. Please note that there may be a charge associated with obtaining a copy of such information. You will be informed of these charges prior to your receipt of the copy.
- ☐ Other (please specify): _____

_____

If you are requesting shipment of records, please specify the delivery address:

_____

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address (if different from above):_____

Telephone (if different from above):_____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE:_____ DATE:_____

All requests for access must be submitted in writing to:

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422