Nickel Obstetrics & Gynecology

222 North J Street Suite A, Tacoma WA 98403 Phone (253) 572-4664 Fax (877) 795-9868

Medical Records Request (Form R)

This form is used for patients to request a copy of their medical records **from Dr. Adam Nickel**. Medical records requests will be processed in 14 days or less. Please complete this form and return it to our office to the above address or fax number. Patients will be contacted by a staff member to discuss any fees or postage costs associated with this request. The size and number of pages in the Medical Record will determine the fees and how the records will be prepared for delivery and will be discussed when we contact you.

Date: ___/___/____

Patient Name: ____ Date of Birth: ________________

Phone Number: (___)________________________

- ○ I am requesting my medical records to be sent directly to me at the below address.
- ○ I am requesting my medical records and I will pick them up (records will only be released directly to the patient unless previous written consent was given. A Photo ID is required at time of pick up)

Address: ____

City: ______________________________________ State: _______________ Zip: ___________________

- ○ I am requesting my medical records be sent to my new medical clinic or health care provider.

Name: ____

Phone Number: __________________________________ Fax Number: ___________________________

Address: ____

City: ______________________________ State: ________________ Zip:_________

Check below desired records to be included:

- ○ Full Medical Record
- ○ Partial record: (please list specific records and dates of service)

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Are you leaving the practice? YES or NO Should we cancel any future appointments? YES or NO

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and alcohol use. If I have been tested, diagnosed or treated HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I request and authorize Nickel Obstetrics and Gynecology to release healthcare information to the above recipient.

____ __________ ______________________________

Signature of patient or authorized representative Date Relationship to signee

This authorization expires 365 days after this request.

Office Use Only: Patient contacted on: __________ Date Records Sent: __/__/___ Fee: __________