

**SOUND INPATIENT PHYSICIANS, INC.
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:

James Kodjababian, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422