PATIENT MEDICAL RECORD REQUEST

This form is to be used by patients only

Print and fill out the information below.
Make your check out to **KJ Document Management, LLC** for the amount of **$60**
Mail your filled out form and check to**:**
15127 NE 24th Street, # 505, Redmond, WA 98052.

All requests will be processed once checks are received and cashed.

Please allow 2-3 weeks for this process.

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
ADDRESS	SEX M F
ADDRESS	PHONE

CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize **KJ Document Management LLC** to disclose the following information to:

DR. / MEDICAL FACILITY EMAIL

ADDRESS CITY, STATE, ZIP PHONE

CONFIDENTIALITY POLICY: I understand that my records are protected under confidentiality policy and Federal regulations, where applicable, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. This consent expires in sixty (60) days.

SIGNATURE RELATIONSHIP TO PATIENT DATE SIGNED