Request for Information

Date of Request _____

Name: _____ Phone No. _____

Address: _____

ID Source and or No. (*WA State Drivers License, etc.*)

_____

Type of Information being Requested: _____

_____

Date of Incident: _____

Location of Incident: _____

_____

Name of Patient: _____

Relationship to Patient: _____

I authorize the above information to be released to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ _____

Signature of Patient **Signature of Patient or Legal Guardian If Patient is a minor**

_____

Signature for Public Information Only