SOUND DIETITIANS

PO BOX 5115
LYNNWOOD, WA 98046

PHONE: 425-409-3544
FAX: 425-354-3544

# Client Request for Sharing of Records

| First Name: | Middle Initial: | Last Name: |
|---|---|---|
| Name at Time of Treatment (if different than above):<br><br>Date(s) of Service: _____/_____/_____ through_____/_____/_____ | | |
| Date of Birth(MM/DD/YYYY): | Phone: | Email (Optional): |

| Street Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

**How would you like your records delivered?**

☐ Paper
- ☐ Home Delivery (complete address above)
- ☐ In-Person Pickup (please schedule a date/time with us for this option)

☐ Electronic (Email) (complete email address above)

☐ To Another HealthCare Provider (list below):

| Recipient Name: | Recipient Phone:<br><br>Recipient Fax: |
|---|---|
| Recipient Mailing Address: | Recipient E-mail (if applicable): |

**Please print your name and sign below:**

| Name of Patient or Personal Representative (please print) | Relationship (please print) |
|---|---|
| | |

| **Signature of Patient or Personal Representative** | **Date/Time** |
|---|---|
| | |

**Please return completed form to:** office@sounddietitians.com or fax/mail to number/address listed above