

TRA Locations

TRA Gig Harbor
TRA Lacey - Center Center
TRA Lakewood
TRA Olympia - on Lilly

TRA Tacoma - on Cedar
TRA Tacoma - on Hilltop
TRA Tacoma - on Union

Affiliated Centers

Carol Milgard Breast Center
Union Avenue Open MRI

Patient Film and Report Request

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____ Last Four SSN # _____

Exam #1 _____ Exam Date _____

Exam #2 _____ Exam Date _____

Exam #3 _____ Exam Date _____

I am requesting (check all that apply):

- Exam Report
- Exam Images on CD
- Exam Images on Film

I would like my records:

- Mailed to my address listed above
- I will pick them up at your clinic: _____
Please indicate the TRA clinic

I hereby authorize _____
(first and last name)

to pick up my TRA film and/or report at on my behalf. They will pick the records up at:

Please indicate the TRA clinic preference

I hereby authorize the release of my records to the following:

- Mail to the below:
- Fax to the below:

Business or Health Care Facility _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Authorizing Signature _____ Date _____

Relationship to Patient _____

Send this form to Medical Records Department: Fax (253) 383-0730, or PO Box 1535, Tacoma WA 98401

Please note: Email is not a secure way to send personal information. To protect your privacy, we recommend you mail or fax this form.

TRA Staff Member _____

Date _____ Patient MRN _____