UW Medicine
VALLEY
MEDICAL CENTER

REQUEST FOR PUBLIC RECORDS

DATE OF YOUR REQUEST: _____

CONTACT INFORMATION:	
Name (First and Last):	
Mailing Address:	
Contact Number:	
Email (optional):	
Fax (optional):	
INFORMATION REQUESTED:	
In the space below, please provide a detailed description of the specific public records being requested:	
How would you like to receive these records? ☐ Mail ☐ Email ☐ On-site review	

Please return this completed form by email, mail, or in person:

IF BY EMAIL:	**IF BY MAIL:**	**IF IN PERSON:**
VMC-PROfficer@Valleymed.org	Valley Medical Center Attn: Patricia Nishikawa, PRO PO Box 50010 Renton, WA 98058	Valley Medical Center Administration Office, MAC 400 S. 43rd Street, M/S VMC 1-019 Renton, WA 98058