Oregon Health & Science University
Hospitals and Clinics
Health Information Services/
Medical Correspondence
3181 SW Sam Jackson Park Rd.
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

REQUEST TO INSPECT OR OBTAIN A COPY OF OWN HEALTH INFORMATION

(There may be a fee for the processing and copying of your health records)

Please complete the following information. (Please print)

PATIENT NAME: _____
Last First Middle

BIRTHDATE: _____

Phone Number: _____ Email: _____

1. Please disclose my protected health information (PHI)

☐ To myself

Via: ☐ MyChart ☐ Email ☐ Fax ☐ Mail Disc ☐ Mail Paper

☐ To the following designated person (other than myself)

Via: ☐ MyChart (Current Proxy) ☐ Email ☐ Fax ☐ Mail Disc ☐ Mail Paper

Name: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ Fax: _____ Email: _____

2. Indicate the health information you wish to receive (see definitions below):

☐ Health care provider reports ☐ X-ray reports ☐ Immunizations records

☐ Lab reports ☐ ER reports ☐ Billing reports

☐ Other, specific Information: _____

MR1470

Signature of Patient or Legal Representative _____ Date: _____
(For identification purposes only)

Printed Name of Patient or ((If applicable) Legal Representative _____

Legal Representative's Relationship to Patient (Include documentation of authority of signer) _____

DEFINITION OF REPORTS:

- Health care provider reports include Discharge Summary, History & Physical exam, any procedures or operations, Clinic Visit Notes
- X-rays include X-ray reports, Ultrasound, MRI, and special Imaging reports
- Labs – all laboratory test results
- ER – Emergency room reports by physician
- Billing – Hospital and/or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed