



**Oregon Health & Science University
Hospitals and Clinics
Health Information Services/
Medical Correspondence**
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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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: _____

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



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