Patient Request for Medical Records

Legacy Health Release of Information, P.O. Box 2868, Portland OR 97208, FAX (855) 892-7124

Please print clearly -See back of page for instructions to fill out this form.
Failure to follow instructions can result in a processing delay.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

Mailing Address: _____City:_____ State:_____ Zip Code:_____

Phone Number: _____ Is it ok to leave a detailed message? ☐Yes ☐ No

2. INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE LOCATION PER COMPLETED FORM)

☐ LEGACY EMANUEL MEDICAL CENTER/ INCLUDING RANDALL CHILDRENS HOSPITAL
☐ LEGACY GOOD SAMARITAN MEDICAL CENTER/ INCLUDING RIO
☐ LEGACY MERIDIAN PARK MEDICAL CENTER
☐ LEGACY MEDICAL GROUP (**specify clinic**) _____
☐ LEGACY HEALTH PROVIDER(S) (**specify**) _____
☐ LEGACY SILVERTON MEDICAL CENTER
☐ LEGACY MT HOOD MEDICAL CENTER
☐ LEGACY SALMON CREEK MEDICAL CENTER
☐ UNITY BEHAVIORAL HEALTH

3. INFORMATION TO BE RELEASED

Date from: _____ to: _____

☐ Emergency Dept Records
☐ Discharge Summaries
☐ History & Physical Reports
☐ Hospital Progress Notes
☐ Immunizations
☐ Lab/Pathology Reports
☐ Radiology Reports
☐ Radiology Images – *only available on disc*
☐ LMG Clinic Notes
☐ Billing Records
☐ Other (**specify**) _____

4. FORMAT OF RECORDS (SELECT ONLY ONE)

☐ Email
☐ MyHealth (Active MyHealth account required)
☐ CD (Only PC compatible)
☐ DVD (Only PC compatible)
☐ Paper

5. MY RIGHTS

Should I choose to have my records sent to someone other than myself, I understand that I **must initial** the following items **only if I wish this information to be released with this request**:

_____ Mental health information and/or records (Oregon only)
_____ HIV-positive test results and HIV diagnosis
_____ Drug/alcohol treatment or referral information. Per federal regulations, describe how much and what of Drug/Alcohol information Is to be disclosed: _____
_____ Genetic testing information and/or records (Oregon only)
_____ Other sexually transmitted diseases (Washington only)

Legacy Health may deny this request under limited circumstances as provided in federal regulations governing the use and disclosure of protected health information. I understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed independent practitioner selected by Legacy Health who did not participate in the decision to deny my request. **Patients receiving their own records will be charged according to HIPAA guidelines. Other parties/organizations receiving records for legal or commercial use will be charged the legally allowed third party State rate.* Patient completing this request for records are responsible for notifying legal or commercial recipients they will receive an invoice for the above mentioned rates.** Medical records will be mailed to the address listed in section 1, unless otherwise indicated by filling in section 5. Records are only sent to one address per request form.

6. INFORMATION TO BE RELEASED TO

Myself (Select ONLY one) ☐ Mail my records to my address listed above ☐ Send records to my active MyHealth Account**
☐ Email records to my email address _____

Or send my records to:

☐ Organization/ Person* _____ Relationship to Patient: _____
Address _____
City, State, Zip _____ Phone _____
Fax _____ Email records to_____

7. SIGNATURE

Signature of Patient or Patient's Healthcare Representative _____ Date _____
(If not signed by the patient, see information on the back page). (Required) (Required mm/dd/yyyy)

Printed name of person signing this form _____ Relationship to patient _____
(Required) (Required)

MINOR PATIENT (age 13-17) _____ Date _____
(Minors Signature required in addition if between the age of 13-17 years old) (Required mm/dd/yyyy)

Patient Request for Medical Records - Instructions

Instructions – Please print clearly – Failure to fill out form completely can result in a delay in processing your request.

- **PATIENT INFORMATION** – Print name, date of birth, complete mailing address and phone number.
- **INFORMATION TO BE RELEASED FROM** – Select a Legacy Medical Center OR the name of the Legacy Medical Group Clinic OR write your Legacy provider's name that you would like your records released from.
- **INFORMATION TO BE RELEASED** – Please add a date range and specify what information you would like released. If you are looking for something that is not listed, please add what you would like to the "Other" line.
- **FORMAT OF RECORDS** – Select CD, DVD, MyHealth**** or Paper. If none is selected, the default format is paper. If you select MyHealth*, records will be sent directly to your MyHealth account. Please note, if you select this option you will need to have an active MyHealth account. If you do not have a MyHealth account, please contact MyHealth Customer Service Monday through Friday, 8 a.m. through 5 p.m., at 503-415-4835 (OR) or 360-487-1075 (WA).
  - **Please note:** Our standard process for releasing electronic records is to send the records in a secure manner. For records requested on disc, we secure the PDF files and send a separate letter with the password to access the records. For records sent by email, you will be sent a secure link. After clicking the link, you will be asked for the demographics of the requested patient and then it will give you the option to download the records that will be sent through a secured sharing site. Also, sending records to your MyHealth account is secured with your account password.
- **MY RIGHTS**
  - Specially protected information in section 5 will only be released if **initialed**.
  - Patients receiving their own records will be charged according to HIPAA guidelines.
  - Other parties/organizations receiving records for legal or commercial use will be charged the legally allowed third party State rate. Oregon rates found in "ORS 192.563". Washington State rates found in "RCW 70.02.010".
  - **Patients completing this request for records are responsible for notifying legal or commercial recipients they will receive an invoice for the above-mentioned rates.**
- **INFORMATION TO BE RELEASED TO** – Specify who the information is to be released to and their relationship to you. You must include a complete mailing address and contacts phone number. Fax number and/or email address as appropriate.
- **SIGNATURE** – Sign and indicate date signed.

  If you are signing this form and you are not the patient
  - If the patient is 18 years of age or older, the patient must sign and date the form.
  - If the patient is 18 years of age or older and is incapable of signing,
    - The personal representative under HIPAA (45 CFR §164.502(g)(1)) may sign and date the form. An attorney for the patient is not a personal representative, under HIPAA unless specifically appointed to make health care decisions for the patient.
    - Please indicate your relationship to the patient (Guardian, Health Care Representative or Health Care Power of Attorney) and include supporting documentation of your relationship.
  - If the patient is a minor aged 13-17, the minor's signature is required.

Rates for patients requesting their own records:	
Paper or electronic format:	$ 6.50 Flat Rate
Records able to be sent to your MyHealth account*** (see below)**	No Charge

**** This option requires that you have an active MyHealth account. Additionally, please note that only records from 2011 forward for most Legacy Health Hospitals and clinics are available in our Electronic Medical Record are able to be sent to MyHealth.***

Send the completed form to: Legacy Health Release of Information
P.O. Box 2868
Portland, OR 97208

OR

Fax Number: 855-892-7124

For questions, please contact Legacy's Release of Information office at 503-413-2762
Monday – Friday 8:00 a.m. to 4:30 p.m. (Except for major holidays)

Patient requests are processed in the order they are received. Please allow up to 15 days to process Washington facility requests and up to 30 days for Oregon facilities. We make every effort to complete requests in a timely manner.