Patient Request for Medical Records

Legacy Health Release of Information, P.O. Box 2868, Portland OR 97208, FAX (503) 413-4671

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/yy): _____

Mailing Address: _____

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 ☐ LEGACY GOOD SAMARITAN MEDICAL CENTER

☐ LEGACY MERIDIAN PARK MEDICAL CENTER ☐ LEGACY MT HOOD MEDICAL CENTER

☐ LEGACY SALMON CREEK MEDICAL CENTER ☐ LEGACY MEDICAL GROUP (**please specify clinic**) _____

☐ LEGACY HEALTH PROVIDER(S) (**please specify**) _____

3. INFORMATION TO BE RELEASED

Date from: _____ to: _____

☐ Discharge summaries ☐ Immunizations

☐ Operative reports ☐ Clinic Notes

☐ Emergency Department Records ☐ Radiology reports

☐ Lab/ Pathology Reports ☐ Billing Records

☐ History & Physical reports ☐ Other (**Please specify**) _____

_____

NOTE: Requests for radiology images and billing records are processed by the respective departments and are mailed separately.

4. FORMAT OF RECORDS (SELECT ONLY ONE)

☐ Paper

☐ MyHealth

☐ CD (PC compatible)

☐ DVD (PC compatible)

☐ Email (only to patient)

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) _____ Genetic testing information and/or records (Oregon only)

_____ HIV-positive test results and HIV diagnosis _____ Other sexually transmitted diseases (Washington only)

_____ Drug/alcohol treatment or referral information. Per federal regulations, describe how much and what of Drug/Alcohol information Is to be disclosed: _____

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. **I may be charged for copies in accordance with HIPAA guidelines.**

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.

5. INFORMATION TO BE RELEASED TO

Myself (Select One) ☐ Please call me to pick up records when they are ready ☐ Mail my records to my address listed above.

☐ MyHealth Account ☐ Email records to my email address: _____

Or send my records to:

☐ Organization/ Person _____

Address _____

City, State, Zip _____ Phone _____

6. 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/yy)*

Printed name of person signing this form _____ Relationship to patient _____

MINOR PATIENT (age 13-17) _____ Date _____

(Signature required if applicable)

ROI DEPT Request has been forwarded to the: ☐ Radiology Dept. ☐ Billing Dept. ☐ Other:

RADIOLOGY DEPT ☐ Request has been fulfilled, please scan ☐ Request has been forwarded to ROI ☐ Other:

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.

1. **PATIENT INFORMATION** – Print the patient's name, date of birth, mailing address and phone number.
2. **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.
3. **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.
4. **FORMAT OF RECORDS** – Select paper, CD or MyHealth. If none is selected, the default format is paper. If CD is selected, you will receive a password mailed separately from the CD. 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). You can also email them at myhealthsupport@lhs.org
   - **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, we send the records through a secured sharing site. You will be instructed to sign up for an account to this secured location. Also, sending records to your MyHealth account is secured with your account password.
5. **INFORMATION TO BE RELEASED TO** – Specify what information is to be released.
6. **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,
  - A legally authorized representative may sign and date the form. An attorney for the patient is not a legally authorized representative 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 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  - Please indicate your relationship to the patient (Parent or Legal Guardian) and include supporting documentation if you are a Legal Guardian.

Rates for patient record requests:	**Fees**	
Paper or electronic format:	Paper: $0.02 per page; CD: $0.25 per disc or DVD $0.42 per disc Plus the cost of labor per minute it takes to process the requested records: $0.34 Additionally cost of shipping when applicable and tax when appropriate.	
Records sent to your MyHealth account*	No Charge	No Charge

* This option requires that you have an active MyHealth account.

Send completed **Patient Request for Medical Records** form by mail or by fax:

Mailing Address: Legacy Health Release of Information
P.O. Box 2868
Portland, OR 97208

Fax Number: 503-413-4671

For questions, please contact Legacy's Release of Information office at 503-413-2762 or 360-487-3408
Monday – Friday 8:00 a.m. to 4:15 p.m. (Except for major holidays)

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.