3600

Patient Request to Access/Disclose a Designated Record Set

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

Information requested in this Patient Request to Access/Disclose a Designated Record Set is based on requirements by both state and federal regulations.

You may attach an additional page if more room is needed than provided on the request form.
If you are requesting records for a deceased patient, please submit a copy of the death certification; copy of Power of Attorney, trust or will, if available; driver's license of person requesting medical records; along with the completed request form.

Please forward this form, for **Hospital Medical Record Requests ONLY** to:

Providence St. Joseph Health
Central ROI
P.O. Box 4950
Portland, OR 97208
Email: ROIHIMreception@r1rcm.com
Phone: (855) 234-2491 | Fax: (855) 234-2493

Please Note: PSJH no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in medical records that are more than a few years old.

Medical Records you are requesting may not be available due to the state retention requirements.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call 888-311-9127 (Swedish Edmonds 888-311-9178) (TYY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711).

注意：如果您講中文, 我們可以給您提供免費中文翻譯服務, 請致電 888-311-9127 (TYY: 711)

PATIENT REQUEST TO ACCESS/DISCLOSE A DESIGNATED RECORD SET

EXPLANATION:

This authorization is being requested of you to comply with state and federal regulations.

Patient's Name:	Date of Birth:	
Prior Name(s) Used:	Phone #:	
Patient's Address:		
City:	State:	Zip Code:
Email Address: @		

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize PSJH to release my medical records to: ☐ Myself OR ☐ Recipient listed below:

Recipient's Name:	Attention:	
Recipient's Address:		
City:	State:	Zip Code:
Phone: Fax:		
Delivery Option: ☐ MyChart ☐ Paper (Mailed) ☐ CD (Mailed) ☐ FAX ☐ Email: _____@_____		

INFORMATION TO BE RELEASED:

I am requesting information from the following Hospital(s):

List Hospital(s)	Specify the Dates of Treatment

INFORMATION TO BE RELEASED (Only check one box in this section):

☐ Pertinent information **(This is what most patients and physicians need)**. Discharge Summary, Emergency Department Report, History and Physical, Consultations, Operative Reports, Labs, Radiology Reports, EEG, EMG, EKG, Pathology Reports. (A fee may be charged)

☐ All/Entire Medical Record **(Includes pertinent information plus all other documentation in the medical record)** (A fee may be charged)

☐ Other (specify): _____

☐ Last two years only **(Specify print package):**
☐ Pertinent Information ☐ All/Entire Medical Record

ADDITIONAL AUTHORIZATION REQUIRED FOR THE FOLLOWING DUE TO STATE/FEDERAL STATUTES:

I specifically authorize release of the following information **(check, initial and date as appropriate)**:

☐ Mental Health treatment information	Initial and Date:
☐ HIV test results	Initial and Date:
☐ Alcohol/drug treatment information	Initial and Date:
☐ Sexually Transmitted Disease (WA Only)	Initial and Date:

PURPOSE:

Purpose of requested use or disclosure: ☐ Patient Request ☐ Continuing Care ☐ Legal ☐ Insurance
☐ Other: _____

EXPIRATION:

This Authorization expires (Date): _____
If no Date is given, this authorization will expire in six months from the signature date.

MY RIGHTS:

I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Providence St. Joseph Health
Health Information Release of Information/Revoke Authorization
P.O. Box 4950
Portland, OR 97208

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE:

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse)	Date:

If signed by someone other than the patient, state your legal relationship to the patient and please provide, i.e, copy of DPOA, Death Certificate, Guardianship:

Relationship to Patient:	Date:

Dependent on State Regulations, authorization from the physician who attended the patient during their stay may be required.

HOSPTIAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED by Physician Name: _____Date:_____HIM-ROI CG Initials:_____

☐ DENIED – REASON FOR DENIAL: _____

MD Signature:_____Date:_____ Time:_____