



Patient Request for Medical Records

Please complete all required sections marked with an asterisk*

*1-Patient's Last Name	*2-Patient's First Name	3-Patient's Middle Name
*4-Patient's Date of Birth	5-Other Names Patient is Known By (if applicable)	
*6-Address of Person Signing Form Records are to be sent to this address ☐ Yes ☐ No (if no, complete Box 12 & 13)		*7-Phone number of Person Signing Form Okay to leave a detailed message? ☐ Yes ☐ No
*8-Description of Records Being Requested For Time period From _____ to _____ ☐ Hospital *From (Name of Legacy Hospital (s)): _____ May include: Patient Demographics, Discharge summary, History & Physical, Consultation, Operative / Procedure notes, Emergency Dept notes, Lab results and Imaging/ Diagnostic results. ☐ Clinic *From (Name of Legacy Clinic(s)): _____ May include: Patient Demographics, Ophthalmology Reports, Medication Information, History & Physical, Procedure notes, Consultation, Lab results and Imaging/ Diagnostic results. ☐ Billing Records From (Name of Legacy Facility): _____ ☐ Other (List Legacy Location and Type of Records): _____		
☒ <u>Legacy Health will charge and collect fees from the person signing this form.</u> ☒ Medical records will be mailed to the address listed in Box 6 of this form, unless otherwise indicated by filling in Box 12. Records are only sent to one address per request form. We do not fax records. ☒ 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. ☒ To request an electronic copy of medical information contact Legacy Health Release of Information Office at: (503) 413-2762		
*9-Today's Date	*10-Patient or Authorized Person's Signature	
*11-Name of Person Signing Form & Relationship to Patient (Documentation of authority to sign is required if signed by anyone other than the patient or the parent of a child under 18 years old.) ☐ Patient ☐ Parent or ☐ Other (Print Name): _____ If you are requesting records be sent to another party please fill out the information below		
12 -Name and Address of receiving party		13- Phone number of receiving party

