

Client/Patient Request for Access to Records

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| Patient/Client Name (Please Print): | Patient/Client Medical Record Number: | Patient/Client Date of Birth: _/_/____ |
| Mailing Address: | Telephone Number: | Date of Request: _/_/____ |

- We cannot give you access to a clinician’s private psychotherapy notes
- We cannot give you access to information that we are no longer required to retain
- If we deny your request, you have the right to request that we review that decision
- You may be charged a fee for copies of your record

I request access to the following records or information (Please include dates):

I want you to include my Substance Use Disorder (SUD) and mental health treatment records

Send My Information to (Only check one box)

- Me
 Directly to the designated third party listed below:

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|----------------------|
| Name (Please Print): |
| Mailing Address: |

Format/Way that you want the information to be sent:

- Electronic copy. You may be able to access your health information via MyChart at <https://mychart.ochin.org>
 Email _____@_____ We will email the records you request in a password protected file. *If you want us to email records using non-secure email check here*
 Secure, password protected CD/DVD
 Send on a secure/password protected USB drive
 Send paper copy via US Mail
 Pick up paper copy in person at _____
 View in person. An appointment will be scheduled for you to view your records in person.

Signature of Patient/Client/Authorized Representative _____ Date _____

Printed Name of Patient/Client/Authorized Representative _____ Relationship to Patient/Client _____

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| Mental Health and Addictions Records P: 503-722-6855 F: 503-722-6897 HC-BHRecords@clackamas.us | Clackamas Health Centers Health Information Management Department (HIM) 20561 Kaen Road Suite 367 Oregon City, OR 97045 | Medical and Dental Records P: 503-650-3195 F: 503-650-3938 HC-PCRecords@clackamas.us |
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