Request a Copy of Your Own Health Records
Clackamas County Behavioral Health Division

Legal Name:_____ Birth Date:_____

Name if Different from Legal Name:_____

Phone Number:_____

Who would you like us to give your records to?

___ Myself
___ Legal Guardian

___ The following person other than myself *(must complete an Authorization to Disclose Protected Health Information Form):*

Name:_____

Phone:_____

What information from your health record would you like? (please include details)

_____

_____

How would you like us to provide these records?

___View In Person ___Pick Up Copy ___Fax:_____

___Secure Email:_____

___Mail (provide address):_____

___Other (provide details):_____

_____

Signature of Individual/Legal Guardian Printed Name Date

Return this form to:

Email: BHBillingandRecords@clackamas.us **Fax:** 503-742-5312

Mail: 11211 SE 82nd Avenue, Suite O Happy Valley, OR 97086 **Phone:** 503-742-5335