WesternU Health
Oliver Station

Authorization for Patient Access To/Release of Medical Records from WesternU Health

5909 SE 92ND AVE
PORTLAND, OR 97266
Phone: 503-771-0055 Fax: 503-771-1908

It is my understanding that I have the legal right, with certain limitations, to either view or obtain copies of my protected health information, or that of my unemancipated minor child whose treatment authorized. This right is also granted to the guardian of a minor child and to the conservator of a person. Further, I understand that when deemed advisable by a healthcare provider, this right may be denied pursuant to the law. In such an event, I will be advised of my options.

I understand there is a charge for obtaining copies of medical records. The charge is $15.00, plus 25 cents per printed/copied page, or 50 cents per page if printed from microfilm.

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Medical Record #: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

The type of access requested is: (check one)

- ❑ Entire medical record of above named patient
- ❑ Inspection of the record
- ❑ Copies of the record

Description of the records to be released:

- ❑ All Records
- ❑ Lab Results
- ❑ Immunizations
- ❑ Billing Records
- ❑ Diagnostics Images

I understand that my medical records may contain information related to HIV/AIDS test results; drug and alcohol abuse, diagnosis or treat; and/or mental health.

Please INITIAL the appropriate box below if you are specifically authorizing the release of these records (Otherwise, this information will be excluded):

- ❑ HIV/AIDS test results
- ❑ Drug and Alcohol Abuse, Diagnosis or Treatment
- ❑ Mental Health

Dates of treatment from: _____ **to** _____

The following sections of the record only: (be specific as possible; for example, lab results only, immunizations only)

_____

_____

_____

_____

Form of Delivery:

- ❑ Mail to address listed above
- ❑ Mail to:

_____

_____

- ❑ Parent/Guardian of minor patient will pick-up
- ❑ Conservator of person, psychiatric*
- ❑ Call and leave information on phone messaging device or family member *Requires written legal proof of guardianship or conservatorship*

Printed Name of Person making request: _____

Signature: _____ **Date:** _____

Relationship to Patient, IF not Patient: _____

Note: A photocopy or electronic scan of this document shall be as valid as original

FOR OFFICE USE ONLY

Processing Date: _____ **Total Amount of fee: $**_____ **Paid by CK#:** _____ **CREDIT CARD CASH**

Date Mailed/Hand Delivered: _____ **Special handling request: YES NO**

Signature of Staff Completing Request: _____