Member Request for Records

Revised February 2019

CareOregon

Part A: Member information

Last name: _____ First name: _____

Middle name: _____ Member ID #: _____ Date: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

DOB: _____ Phone #: _____

Part B: Access to records

In accordance with the HIPAA Privacy Rule, I request a copy of the following records held by CareOregon:

◯ Medical and pharmacy claims for the range of dates from: _____ to: _____

◯ Designated record set* claims, and case management records maintained by CareOregon relating to the following: service or claim (specific date and/or medical claim):

_____

**NOTE: Designated Record Set is limited to medical and pharmacy claims and case management records maintained by CareOregon or used, in whole or in part, by CareOregon to make healthcare decisions.*

I specifically authorize the release to me of the following, if such are part of my record. Please initial to include:

HIV/AIDS: ☐ Chemical dependency: ☐ Mental health: ☐ Genetic testing: ☐

Part C: Form, format and manner of access request

Check below on how you wish to receive the records:

◯ **Paper copies:** I would like paper copies of the requested information:

◯ Mailed to me (at the mailing address above) ***OR*** ◯ Mailed to me at a different mailing address *(please provide alternate address below)*

Alternate street address: _____

City: _____ State: _____ ZIP code: _____

◯ **Inspection:** I would like to inspect the above information at CareOregon during regular business hours (8:00 a.m. – 5 p.m.).

If my request is granted, please:

◯ **Call me via telephone** (at the number above) ***OR*** ◯ **Mail me a letter** (at the address above)

To let me know when I may come to CareOregon to review the information.

◯ **Electronic copies:*** I would like electronic copies of the requested information emailed to me at the following address:

Email: _____

**By requesting electronic copies and signing this form, I acknowledge that I am aware of and assume the risks associated with transmitting unencrypted email, including that it may be intercepted, forwarded, printed and stored by others. I understand CareOregon is not responsible for unauthorized access of PHI while in transmission to me or the third-party I assign to receive and is not responsible for safeguarding my information once it is delivered to me or the third-party assigned to receive.*

CareOregon

Part D: Member signature or authorized representative/guardian

Member signature or Designated Legal Representative/Guardian signature:

_____ Date: _____

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative and attach supporting documentation.

Mail completed form to:
CareOregon
Audit and Compliance
315 SW Fifth Avenue
Portland, OR 97204

Or fax to:
(503) 416-3662

CareOregon Use Only

Date received: _____ Request accepted _____ Request denied_____

Reason: _____

Date and time appointment set for member to review copy of their records: _____

Signature: _____ Title: _____