

Member Request for Records



Part A: Member Information		
Member Last Name:	Member First Name:	Member Middle Name:
Street Address:		
City:	State:	ZIP Code:
Date of Birth:	Phone Number:	Member ID#:

Part B: Access to Records
In accordance with the HIPAA Privacy Rule, I request a copy of the following records held by CareOregon: <input type="checkbox"/> Medical and pharmacy claims for the range of dates from: _____ to _____ <input type="checkbox"/> Designated record set,* claims, and case management records maintained by CareOregon relating to the following service or claim (specific date and/or medical claim): _____ <i>*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> 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: <input type="checkbox"/> Paper Copies I would like paper copies of the requested information: _____ Mailed to me at the mailing address listed above _____ Mailed to me at a different mailing address (Please provide the information below): _____ <input type="checkbox"/> Inspection I would like to inspect the above information at CareOregon during regular business hours (8:00 am – 5 pm). If my request is granted, please: _____ Call me via telephone (at the number listed above) OR _____ Mail me a letter (at the address listed above) to let me know when I may come to CareOregon to review the information <input type="checkbox"/> Electronic Copies** I would like electronic copies of the requested information emailed to me at the following address: _____ <i>** 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.</i>

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.

CareOregon Use Only

Date Received: _____ Request Accepted Request Denied

Reason: _____

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

Signature: _____ Title: _____