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:

☐ 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 listed above

_____ **Mailed to me at a different mailing address**
(Please provide the information below):

_____

☐ **Inspection** I would like to inspect the above information at CareOregon during regular business hours (8 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

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

_____

** *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.*

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: CareOregon, Audit and Compliance, 315 SW Fifth Ave, Portland, OR 97204

Fax: 503-416-3662

Revised: 2/1/2019

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: _____