

Name (Please Print): _____
ID Number (MRN, Prime No. or Case No., etc.): _____
DOB: _____

Request for Access to Own Protected Health Information

You may be able to access your health information via MyChart at <https://mychart.ochin.org>

I request access to the following type of record or information (and dates, if applicable):

Send my information to: (select only one)

- Send paper copy of requested information via US mail to this address: _____
- Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. **Email address:** _____
- Directly to the designated third party listed below.

Name (Please Print):	Phone Number:
Mailing Address:	

*You may be charged a fee for copying your records.

Signature of Individual or Authorized Personal Representative:	Date:
If Personal Representative, relationship to Individual:	

Health Information Services
619 NW 6th Avenue, 9th Floor
Portland, OR 97209
Phone: 503-988-3997
Fax: 503-988-4088
Email: Medical.Records.Request@multco.us