

Department of County Human Services
Request for Access to Own Protected Health Information



Name (Please Print):	ID Number (MRN, Prime No. or Case No., etc.):
Mailing Address:	Date of Birth:
	Date of Request:
Contact Phone:	

- We cannot give you access to any psychotherapy notes and some other types of information.
- We cannot give you access to information that we are no longer required to retain.
- You have a right to request a review if we deny all or a portion of your request.
- You may be charged a fee for copying your records.

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

Send my information to: (select only one)

- Me
- Directly to the designated third party listed below.

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

Format/Manner: (select only one)

- Send electronic copy.

Email address (please print clearly): _____

Note: Information will be sent to the email address provided via secured (encrypted) email unless otherwise specified.

- Send paper copy of information via US Mail.
- View in person. I understand that I will be contacted to arrange for a time to view in person.

First Name and Last Name of Individual or Authorized Representative (Print)	Relationship (Print)
Signature of Individual or Authorized Personal Representative	Date:

Please keep a copy of this form for your records. Return completed form to:

USPS Mail	Email
Department of County Human Services c/o DDSD Central Records 421 SW Oak Street, Suite 610 Mail Stop 167/1/610 Portland, OR 97204	idd.recordsandsupport@multco.us.
	Questions?
	1-503-988-3658