REQUEST FOR HEALTH RECORDS

Oregon Imaging Centers respects your right to access your health information per state and federal regulations. One copy for your personal records is provided free of charge. A $10 fee may apply for additional copies.

Please note that electronic records are available only when the health information is maintained electronically.

LAST NAME	FIRST	MIDDLE
DATE OF BIRTH	**PREFERRED CONTACT** INFORMATION (DAYTIME PHONE OR EMAIL)	

1. I am requesting the following medical records for my personal use. Exam Date: _____

   ☐ Hardcopy radiology report ☐ CD: Includes electronic report and images

   ☐ Electronic Report (via encrypted e-mail)

   E-mail Address: _____

   Please mail requested records to:

2. ☐ Please mail requested records to:

STREET ADDRESS		
CITY	STATE	ZIP CODE

3. ☐ I will pick-up the requested records at the following location:

   ☐ University District ☐ RiverBend Pavilion

Picture ID – government or school ID required at time of pick-up or include a copy with form.

►_____ _____
(SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT) DATE

►_____ _____
(PRINT NAME OF PERSON AUTHORIZED TO SIGN FOR PATIENT) RELATIONSHIP TO PATIENT

FOR OREGON IMAGING CENTERS' USE ONLY		
DATE RECEIVED	BY	VERIFICATION OF IDENTITY AND/OR AUTHORITY
COMPLETED BY(EMPLOYEE SIGNATURE)		DATE