Fora Health

Records Department
PO Box 16040
Portland, OR 97292
P: 503-535-1150, x-1119 | F: 503-535-1191

Records Request Form

Patient Name: ____ DOB: ______________

Timeframe of Records Requested (if known): ____

Records Requested:					
Y ☐	N ☐	Drug and Alcohol Assessments/Evaluations	Y ☐	N ☐	Mental Health Assessments/Evaluations
Y ☐	N ☐	Treatment Plan (Drug and Alcohol)	Y ☐	N ☐	Treatment Plan (Mental Health)
Y ☐	N ☐	Progress Notes (Individual)	Y ☐	N ☐	Urinalysis / UDS Results
Y ☐	N ☐	Medications/Doctor's Orders	Y ☐	N ☐	Case Management Notes
Y ☐	N ☐	Discharge/Transfer Summary Plan	Y ☐	N ☐	Other:

Media format: (choose one)

☐ Paper (hard copy*), ☐ Digital

Any hard copy/paper requests totaling over 30 pages will automatically be provided in digital PDF format on a thumbdrive.

Delivery method: (choose one)

☐ **FAX** *(provide fax number below)*
☐ **MAIL** *(provide mailing information below)*
☐ **EMAIL** *(provide email address below)*
☐ **WILL-CALL*** – To location (check one): ☐ Cherry Blossom, ☐ Hillsboro *(provide phone number below)*

If you are not currently in treatment you will need to provide ID prior to pick-up

Name ***or*** Agency you wish delivered to: ____

Address: ____

Phone: ______________________ Fax: ______________________

Email: ____

Please note: If you are requesting that these records be provided to another person/organization, a signed Release of Information for that person/organization MUST accompany this form.

Signature and date required - *If you wish to proceed with this request, please indicate by signing and dating the spaces below.*

- I understand I bear responsibility for the consequences of my releasing the record to third parties.
- I understand Fora Health staff is available to discuss the record with me, and that Fora Health recommends I meet with a counselor to review my clinical record and I have the right to agree or decline.
- I understand I may ask to add something to my record by submitting a written request.

Patient Signature: ______________________________________ Date: ____________________

Questions regarding requests should be directed to the Fora Health Records Department at (503) 535-1150, ext. 1119.