Fora Health

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

Clinical Records Request

Date of request: ___________________________

Client name (print): ____ DOB: _________________________

This request is for:

☐ Complete record set *(Note: fees may be associated with this request – see POSSIBLE FEES explanation below)*

A portion of the record, specifically:

☐ Intake Assessment ☐ Progress Notes (from individual sessions only) ☐ Transfer Summaries,

☐ Discharge Reports ☐ UA Results ☐ Other: ____

____

Media format (choose one**):**

☐ Paper (hard copy*) ☐ Digital (DVD)

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

Mandatory Information – MUST be completed for Request Processing

Delivery method: (choose one)

☐ **WILL-CALL** – To location (check one): ☐ Downtown ☐ Hillsboro *(*provide phone number below)*

☐ **FAX** *(*provide fax number below)*

☐ **MAIL** *(*provide mailing information below)*

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

Street/PO Box Address: ____

City, State, Zip: ____

Phone: ____ Fax: ____

(Note if you are not currently in treatment you will need to provide ID prior to request pick-up)

POSSIBLE FEES:** Thank you for the opportunity to service your request for the release of medical records. Please note that depending on the request; Fora Health may apply an average *Schedule of Cost* (HITECH act 42 USCA 17935 and Federal Regulation 45 CFR 164.524) for requests of records maintained electronically. We may also apply an *Actual Cost* (ORS 192.563) for older records that were maintained in hard copy paper format. If you wish us to proceed with this request, please indicate by signing and dating the space below and return the form to us. ***Note: You will be notified in advance of any costs associated with your request prior to processing. All fees must be paid in advanced of delivery. Questions regarding requests should be directed to the attention of the Fora Health Records Department at 503-535-1150, x-1119.

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

I hereby acknowledge that I have read and agree to the fees listed within the Oregon Revised Statutes ORS 192.563. Fees are nonrefundable once services are rendered. Payment is due upon receipt of documents and invoice.

- 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.

Signature: ____ Date: ______________________________