Coos Health & Wellness

Together, Inspiring Healthier Communities

ACCESS REQUEST FORM

Client' Name: _____ _____ _____ Birth Date:_____
Last First Middle

Address: _____ _____
Street Zip

Phone #: _____ _____ _____
Home Cell Work

Please check all boxes that apply.
I hereby request that Coos Health & Wellness provide me with ☐ access to **OR** ☐ my own copy of the "Requested Information" checked below:

☐ My medical records.
☐ My billing records.
☐ Any other personally identifiable information used by Coos Health & Wellness to make medical decisions about me.

Please also check one of the three boxes below:

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through_____.
☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by Coos Health & Wellness at a cost to me of $0.15 per page.
☐ I would prefer to receive the Requested Information in the form of a summary prepared by Coos Health & Wellness at a cost to me of $25. I understand the Department is not required to provide the Requested Information in a summary form and will make that determination.

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law.

I understand that Coos Health & Wellness may deny this request under limited circumstances as provided for under federal and Oregon law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Coos Health & Wellness who did not participate in the Coos Health & Wellness's decision to deny my request.

I understand that Coos Health & Wellness will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within five (5) business days of receiving this request if the information is maintained or accessible on-site at Coos Health & Wellness or within five (5) business days if the Requested Information is not maintained or accessible on-site at Coos Health & Wellness. If Coos Health & Wellness is unable to comply with my approved request for information maintained or accessible on-site within five(5) days, it may extend the applicable deadline for up to thirty (30) more days by notifying me in writing.

Please check the appropriate boxes:

I would prefer to ☐ pick-up or view the Requested Information at a mutually agreeable time and place; **OR** ☐ have the Requested Information mailed to me at the following address:

_____

_____

_____

I understand that before the Requested Information is provided to me the Coos Health & Wellness will require proof of my identity.

Please check the appropriate box:
I understand that Coos Health & Wellness will charge me $0.15 per page for the copying services necessary to complete my request, as well as any applicable mailing fees. If I am granted access to the Requested Information, I ☐ would **OR** ☐ would not (check one) like Coos Health & Wellness to provide me with an additional written explanation of such Requested Information at an additional cost to me of $25, if the department determines that it is able to provide a summary.

_____ _____
Signature of Client (or Personal Representative) Date

_____ _____
Printed name of Personal Representative Date

_____
Relationship of Personal Representative to Client

* * * * *

After you have completed this form please return it to the Medical Records Office by mail or by facsimile at the following address:

Medical Records
Coos Health & Wellness
281 LaClair Street
Coos Bay, OR 97420
Fax (541) 888-8726