LEGACY
Health System

PATIENT ACCESS FORM

This form shall be completed when a Legacy Health System (LHS) patient ***OR*** the legal guardian or parent on behalf of a minor requests access to a medical record and/or designated record set. I understand LHS will charge and collect fees from the person requesting copies according to the current LHS Release of Information Fee Schedule for Oregon and Washington. Applicable mailing fees also apply. A deposit may be due before receipt of records. A LHS representative will contact you if a deposit is required. In most cases, an estimate for charges is available upon request.

I understand a valid form of identification is required to fulfill this request before release of information.

SECTION I: PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME
STREET ADDRESS		DATE OF BIRTH

CITY	STATE ZIP CODE	HOME PHONE	WORK PHONE

SECTION II: LHS LOCATION(S) OF WHERE SERVICES WERE PROVIDED

- ❑ Legacy Emanuel Hospital and Health Center
- ❑ Legacy Good Samaritan Hospital and Medical Center
- ❑ Legacy Meridian Park Hospital
- ❑ Legacy Mount Hood Hospital
- ❑ Legacy Salmon Creek Hospital
- ❑ A Primary or Specialty Care Clinic (Please list the specific clinic name):

_____

_____

SECTION III: DATE, DATE RANGE, OR DESCRIPTION OF SERVICES

Date or date range of service: _____

Description of services provided: _____

SECTION IV: DELIVERY METHOD (Records not picked up within 30 days will be destroyed)

- ❑ Pick-up. Please call the appropriate Release of Information Department to confirm when records are ready for pick-up.
- ❑ Mail records to the above address. A deposit based on estimated costs is due when this option is selected.

SECTION V: TYPES OF RECORDS – SELECT ALL THAT APPLY

This section lists the most common types of documentation LHS providers create during a visit.

- ❑ Clinic or Hospital Reports — Summaries created during a hospital, day surgery, or clinic visit
- ❑ Diagnostic Imaging Reports — Summaries created from an imaging test (MRI, ultrasound, etc)
- ❑ Laboratory Testing Results — Test results and/or interpretations from the laboratory

This section lists components of additional documentation LHS providers create during a visit. The information may also be summarized, included and/or found in the above formats.

- ❑ Progress Notes
- ❑ Medication Records
- ❑ Physician Orders
- ❑ Emergency Department records
- ❑ Hospital nursing records
- ❑ Other specific areas of the record:_____

_____

This section lists the most common portions of the patient billing record formats.

- ❑ Claim form
- ❑ Itemized statement
- ❑ Remittance Advice
- ❑ Medicare ABN, Lifetime and/or Notice of Non-coverage letter
- ❑ Other specific areas of the billing record:

_____

I understand I may request access to or obtain a copy of a designated record set maintained by LHS by completing the section titled "Other specific areas of the record" in the section above. I understand I have a right to inspect the above requested information. I understand that any information provided to me pursuant to this request will not include psychotherapy notes (defined as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record), information compiled in a reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law. I understand that LHS may deny this request under limited circumstances as provided for under federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed independent practitioner selected by LHS who did not participate in LHS' decision to deny my request.

_____ _____

PATIENT SIGNATURE OR AUTHORIZED CONSENTER DATE

_____ _____

PRINT NAME OF SIGNER RELATIONSHIP TO PATIENT

INSTRUCTIONS: Mail or fax completed request to the location indicated in SECTION II.
If records are housed at multiple locations, mail request to Legacy Emanuel.

Legacy Emanuel, HIS Release of Information 2801 N. Gantenbein, Room B-045 Portland, OR 97227	PHONE (503) 413-2762 FAX (503) 413-4671
Legacy Good Samaritan, HIS Release of Information 1015 NW 22nd Ave Portland, OR 97210	PHONE (503) 413-7201 FAX (503) 413-6211
Legacy Meridian Park, HIS Release of Information 19300 SW 65th Ave Tualatin, OR 97062	PHONE (503) 692-7487 FAX (503) 692-2479
Legacy Mt. Hood, HIS Release of Information 24800 SE Stark Gresham, OR 97030	PHONE (503) 674-2089 FAX (503) 674-1656
Legacy Salmon Creek, HIS Release of Information 2211 NE 139th St. Vancouver, WA 98686	PHONE (360) 487-3408 FAX (360) 487-3409 or FAX (360) 487-3419

Legacy Health System Employee or Medical Staff Member Use Only

I am a LHS employee or member of the Medical Staff with access to the EMR systems. I would like to access the requested patient records in this manner. I understand LHS will notify me via email or telephone when my request is approved. Access is not approved until notification is made.

Email address: _____ Contact phone/msg #: _____

LHS Health Information Services Use Only

Name of LHS Employee Verifying Identity: _____

Name of LHS Employee Notifying Patient: _____