INSTRUCTIONS FOR COMPLETING THIS FORM

The patient identification information must be completed. If not complete, the form may be sent back to you.

Include the following information:

- Patient's Name (Print clearly)
- Other names the patient has used. If none, leave this blank
- Medical Record Number (If known)
- Date of Birth
- Telephone Number where you can be reached during the day
- Home Street Address
- Home City, State and Zip Code

Purpose or need for your medical record information section:
State the purpose for the release of information.

Examples:

- Insurance application
- Insurance Claim
- Legal
- Benefits
- School
- Transfer to another provider
- Patient Care, etc.
- *(For personal use* may be used only if you are releasing records to yourself).

The format I wish to receive my records section:
Please indicate media type and delivery preference. If no options are checked, the default will be CD and USPS delivery.

Information to be released from:
List the name and address of who has the information that you want released, state specifically which hospital or clinic*. If you are not specific there may be a delay in completing this request.*

Information to be released to:
List the name, address, fax, and phone number where you would like the information sent.
If you are not specific there may be a delay in completing this request.

Write the name or company of who is to receive the information. Include:

- Name or Company
- Title of who is to receive the information. Examples: Attorney, Physician, etc.
- Telephone of the person or company who will receive the information
- Street address of who will receive the information
- City, State and Zip Code of who will receive the information

Information to be released:

- Place a check mark next to the information you would like released.
- Checking All records will allow the release of any records needed to respond to your request unless there is sensitive information.
- By checking “Other” you will need to describe exactly what you want released.
- Examples: All records regarding my back injury, or All information needed to complete the attached form, etc.
- INITIAL for any sensitive information protected by law you want to be released. These items will not be release if not checked.

For X-ray films, MRI, or other imaging, if you want the actual films/images your request must go directly to the Imaging department, you can contact them at Medford 541-789-7154, Grants Pass 541-472-7140, Ashland 541-201-4377

Rogue Regional Medical Center &
Asante Physician Partners
Health Information Services
2825 E. Barnett Road
Medford, Oregon 97504
PH: 541-789- 4206 Fax: 541-789-4510

Three Rivers Medical Center
Health Information Services
500 S.W. Ramsey Avenue
Grants Pass, Oregon 97527
PH: 541-472-7133 Fax: 541-472-7129

Ashland Community Hospital
Health Information Services
280 Maple Street
Ashland, Oregon 97520
PH: 541-789-1385 Fax: 541-488-7413

Patient Name:________________________________

Previous Name (if applicable) __________________ Date of Birth: ______________

Address:______________________________________ City___________________ State___________ Zip _________________

Phone:_______________________ Email: ______________________________________

THIS FORM IS FOR THE PATIENT OR THEIR DESIGNATED PERSONAL REPRESENTATIVE TO REQUEST ACCESS TO OR A COPY OF THEIR MEDICAL RECORDS

The purpose or need for the copy of your medical record information: (circle one or fill in other)

Personal Use Transfer to another provider Legal Use Continuing care Other:

How would you like to receive records is:(circle one)

Electronic: disc flash drive Email/encrypted Email/Unencrypted My Chart, paper, fax ____________________________

Other: ____________________________________ If applicable choose one: pick up, mail

If Email is circled above, then choose one of the following:

☐ Email (non-encrypted) I understand that not encrypting email increases the risk that information could be ready by an unauthorized third party. read or otherwise accessed by a third party while in transit.

☐ Email (encrypted) Note: Encrypted emails require a registration process upon receipt of the first email.

Information to be Released FROM:		**Information to be Released TO: Patient or Third-party**	
Organization Name i.e. hospital name, Provider name, Clinic		Name, Title, Organization, Provider or Attorney ETC.	
Address	City, State, Zip	Address	City, State, Zip
Phone	Fax	Phone	Fax

What records do you want? (Check appropriate boxes below):

Date of Service: ____/_____/______ through ____/____/_____ ED visit date: ____/____/______

☐ Most recent two year history ☐ Clinician office chart notes ☐ Medical records needed for continuity of care

☐ Discharge Summary ☐ Discharge Instructions ☐ Operative/Procedure Report

☐ History & Physical Report ☐ Physical therapy records ☐ Billing statements

Test Results (X-Rays, Lab/Pathology Results) please specify: ____

Other (Immunization Records, Medication Lists) please specify: ____

☐ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

The information requested is limited to: ☐ Treatment for:____

IMPORTANT –Sensitive Information: By initialing the space(s) below, I am specifically authorizing the release of the following: ☐ HIV (Human Immunodeficiency virus) test results ☐ Psychiatric (Mental Health) records ☐ Genetic Testing records

Signature of Patient or Personal Representative _______________________________________ **Date**__________________

Description of Personal Representative's Authority____________________________________ **Date** __________________

Notice of Nondiscrimination

Asante complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Asante does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Patient Protection and Affordable Care Act and regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84 and 91.

Asante:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters or video remote interpreting services
- Written information in other formats (large print, audio, accessible electronic, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters or video remote interpreting services
- Information written in other languages

If you need these services, ask your health care provider. You may also contact the Resource Management Department or the hospital's house supervisor.

If you believe that Asante has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Asante corporate compliance officer
2650 Siskiyou Blvd., Medford, OR 97504
(541) 789-5668; TDD or State Relay (541) 789-7104

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

If you speak another language, language assistance services, free of charge, are available to you. Call 541-789-5322; TTY: 541-789-7104.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 541-789-5322 (TTY: 541-789-7104).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 541-789-5322 (TTY: 541-789-7104).

Chinese: 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 541-789-5322 (TTY: 541-789-7104).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 541-789-5322 (телетайп: 541-789-7104).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 541-789-5322 (TTY: 541-789-7104) 번으로 전화해 주십시오.

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 541-789-5322 (телетайп: 541-789-7104).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 541-789-5322 （TTY:541-789-7104）まで、お電話にてご連絡ください.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 5417895322
رقم هاتف الصم والبكم: (TTY: 541-789-7104)

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 541-789-5322 (TTY: 541-789-7104).

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 541-789-5322 (TTY: 541-789-7104)។

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 541-789-5322 (TTY: 541-789-7104).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 541-789-5322 (TTY: 541-789-7104).

Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با
541-789-5322 (TTY: 541-789-7104) تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 541-789-5322 (ATS: 541-789-7104).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 541-789-5322 (TTY: 541-789-7104)