adapt
Integrated Health Care

REQUEST TO INSPECT, REVIEW AND/OR COPY A CLINICAL RECORD

If request is signed to a 3rd party, a completed Release of Information must accompany this form.

Date of Request:	
Full Name of Patient / Client:	
Patient Date of Birth:	
Patient Medical Record Number:	
Patient / Client Requesting Records for:	☐ Self ☐ 3rd Party
Prefer to:	☐ Pick up Record(s) at Adapt ☐ Have Record(s) mailed
Patient / Client Contact Information:	
Full Name:	
Street Address:	
City, State Zip:	
Phone:	Email:

Complete This Section:

I, _____, am requesting to inspect/copy the above
(Your Name)

listed clinical record for the purpose of _____

Approximate date(s) requested and branch of Adapt Integrated Health Care where patient/client received treatment services:_____

Please check below the information that you are requesting a copy of:

☐ Dates of Service ☐ Assessment ☐ Completion Certificate/Letter of Completion

☐ Progress Notes ☐ UA Results ☐ Primary Care Records

☐ Other (specify): _____

_____ _____

Signature of Person Requesting Information **Date**

How to Submit Request

By Mail:
Adapt Integrated Health Care
ATTN: Health Information Management Dept.
P.O. Box 1121
Roseburg, OR 97470

By FAX:
1-844-926-1370

By Email:
records@adaptoregon.org

Questions

If you have questions or need assistance, call 541-464-3929.