



De Paul Treatment Centers  
Records Department  
PO Box 3007  
Portland, OR 97208  
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; De Paul Treatment centers 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 De Paul 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 De Paul staff is available to discuss the record with me, and that De Paul 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: \_\_\_\_\_

