Member Request for Records

Jackson Care Connect™
Part of the CareOregon Family

Part A: Member information

Last name: _____ First name: _____

Middle name: _____ Member ID #:_____ Date: _____

Street address: _____

City: _____ State:_____ ZIP code: _____

DOB: _____ Phone #: _____

Part B: Access to records

In accordance with the HIPAA Privacy Rule, I request a copy of the following records held by Jackson Care Connect:

◯ Medical and pharmacy claims for the range of dates from: _____ to:_____

◯ Designated record set,* claims, and case management records maintained by Jackson Care Connect relating to the following: service or claim (specific date and/or medical claim):

_____

**NOTE: Designated Record Set is limited to medical and pharmacy claims and case management records maintained by Jackson Care Connect or used, in whole or in part, by Jackson Care Connect to make healthcare decisions.*

I specifically authorize the release to me of the following, if such are part of my record.
Please initial to include:

HIV/AIDS: _____ Chemical dependency:_____ Mental health: _____ Genetic testing: _____

Part C: Form, format and manner of access request

Check below on how you wish to receive the records:

◯ **Paper Copies** I would like paper copies of the requested information:

◯ **Mailed to me** (at the mailing address above) ***OR*** ◯ **Mailed to me at a different mailing address**
**Please provide alternate address below.*

*Alternate address: _____

◯ **Inspection** I would like to inspect the above information at Jackson Care Connect during regular business hours (8:00 a.m. – 5 p.m.).

If my request is granted, please:

◯ **Call me via telephone** (at the number above) ***OR*** ◯ **Mail me a letter** (at the address listed above)

To let me know when I may come to Jackson Care Connect to review the information.

◯ **Electronic copies**** I would like electronic copies of the requested information emailed to me at the following address:

Email: _____

***By requesting electronic copies and signing this form, I acknowledge that I am aware of and assume the risks associated with transmitting unencrypted email, including that it may be intercepted, forwarded, printed and stored by others. I understand Jackson Care Connect is not responsible for unauthorized access of PHI while in transmission to me or the third-party I assign to receive and is not responsible for safeguarding my information once it is delivered to me or the third-party assigned to receive.*

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Part D: Member signature or authorized representative/guardian

Member signature or Designated Legal Representative/Guardian signature:

_____ Date: _____

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative and attach supporting documentation.

Please note, processing can take up to 30 days before the requested records are released.

Mail completed form to:
CareOregon
Member Records Request
315 SW Fifth Avenue
Portland, OR 97204

Or fax to:
503-416-3723

CareOregon Use Only

Date received: _____ Request accepted _____ Request denied_____

Reason: _____

Date and time appointment set for member to review copy of their records: _____

Signature: _____ Title: _____