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MEDICAL RECORDS REQUEST

Send Records to (Name of Physician or Practice):	Date:

Patient Name:	MR#:
Date of Birth:	Call Back:
Exam:	Exam Date:

Request to have delivered: ☐ Report only ☐ Report and Images

METHODS OF DELIVERY FOR REPORTS. Please select al least one method:

☐ Email report: ____________________

☐ FAX report: ____________________

☐ Mail report: ____________________

METHODS OF DELIVERY FOR IMAGES. Please select al least one method:

☐ Email report and link to study images

Email address: ____________________

IF EMAILING RECORDS, CASE-SENSITIVE PASSWORD:

Case-sensitive password: ____________________
(Minimum 6 characters. Please indicate capital letters by underlining.)

☐ Push images (and fax report to film library w/image count)

- ○ OHSU 503-494-5020
- ○ Oregon Clinic 503-935-8914
- ○ Providence St. Vincent 503-216-6635
- ○ Providence Portland 503-215-0291
- ○ Columbia Memorial Hospital 503-338-4026
- ○ Compass Oncology - Salmon Creek 360-487-1619
- ○ Legacy Emanuel 503-413-4402
- ○ Legacy Good Samaritan 503-413-8169
- ○ Legacy Meridian Park 503-692-2476
- ○ Legacy Mt. Hood 503-674-1626
- ○ Oregon Ortho & Sports Medicine 503-691-6167
- ○ Sports Medicine Oregon 503-692-8710

☐ Dr. would like to be setup to view online. Please provide name and number of contact person.

____

☐ Mail CD to study images: ____________________

Notes: ____________________

Day and Time needed: Day: ____________ Time: ____________
(DO NOT put "STAT", date and time required)

Send Records to (Name of Physician or Practice): ____________ Phone#: ____________

Date Completed: ____________ Initials: ____________