ROGUE VALLEY UROLOGY
PHYSICIANS AND SURGEONS, PC

www.RogueValleyUrology.com

PATIENT REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

To access or obtain a copy of your patient records, please complete and return this form to:

Rogue Valley Urology
1698 East McAndrews Road, #280
Medford, OR 97504

Fax: (541) 732-3910
E-mail: info@rvurology.com

**** To be completed by patient or personal representative:***

Date of records request: _____/_____/_____

Patient: _____ **Date of Birth**: ____/____/____
Address: _____
_____

What are the date(s) of treatment for which you would like records?

☐ Treatment provided between ____/____/____ to ____/____/____.
☐ Treatment provided at anytime.
☐ Other:_____

What type of records would you like to obtain?

☐ Medical records (*please specify*)
- ☐ History and physical, exam notes, progress notes, etc.
- ☐ Consultation reports.
- ☐ Operative, surgical, and procedure reports.
- ☐ Laboratory, pathology, and other test results.
- ☐ Diagnostic, images, films, or other recordings (e.g., x-rays, MRI scans, CT scans, photos, etc.)
- ☐ Other: _____

☐ Billing and payment records.
☐ Electronic copy of records identified above (identify requested format).
☐ Other: _____

How would you like to receive the records?

☐ Patient will pick up copies of records from the PROVIDER.
☐ Send the records to the following address: _____
_____
_____

☐ Send the records electronically to the following email address (please note e-mail is unsecure):
_____

☐ Other: _____

I certify that I am the patient identified above or that I am the person with legal authority to make health care decisions for the patient identified above.

Name: _____ Date: ____/____/____
Signature: _____
Telephone: _____

If personal representative, describe relationship to patient or authority: _____
_____