Member Records Request Form

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

Instructions: Please complete all parts of the form below to request a copy of your record set.

Part A: Member Information

First Name: _____ Last Name: _____

Middle Name: _____ Member ID#: _____

DOB: _____ Phone Number: _____

Street Address: _____

City: _____ State & Zip Code: _____

Part B: Access to Records

In accordance with the HIPAA Privacy Rule, I am requesting a copy of the following records held by CareOregon for the range of dates from: _____ to _____ (select all that apply):

- ☐ Medical Claims Report
- ☐ Pharmacy Claims Report
- ☐ Dental Claims Report
- ☐ Case Management Records
- ☐ Appeal and Grievance Records
- ☐ Authorization Decision(s)
- ☐ Health Related Flex Funds Decision(s)
- ☐ Other (*please specify in box below*)

I specifically authorize the release of the following protected categories, if such are part of my records:

***Initials are required for each protected category you wish to include (*initial each applicable box*):**

☐ **HIV/AIDS** ☐ **Chemical Dependency** ☐ **Mental Health** ☐ **Genetic Testing**

Part C: Form, Format and Manner of Access Request

Please check below on how you wish to receive your records:

Paper Copies:

☐ I would like paper copies of the requested information:

☐ Mailed to me at the mailing address listed above OR ☐ Mailed to me at a different mailing address (*please provide alternate address below*)

Alternate Mailing Address: _____

City _____ State & Zip Code: _____

Electronic Copies (*CareOregon delivers these records via an encrypted email*):

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

Email: _____

Revised Date: 4/30/2026

I understand CareOregon 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 return this form using the methods below:

Mail
CareOregon Privacy Team
Member Records Request
315 SW Fifth Avenue
Portland, OR 97204

OR

Fax
(503) 416-3723

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