

# **VANCOUVER CLINIC**

Patient Request for Records 45 CFR 164.524

Medica	al Record Numl																	
*Patient Name (please print clearly):																		
*Date	of Birth:																	
*Addre	ess:																	
City:												Zip Code:						
*Phon	e Number:																	
	Address (REQ																	
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*Patient or legally authorized representative signature										te							-	
Relationship to Patient if signed on behalf of patient										Printed name if signed on behalf of patient								

Release of Information (13898 NE  $28^{th}$  St., Suite B109, Vancouver, WA 98682) PHONE 360 397-3638, FAX 360 604-1714, Radiology FAX: 360 604-1778

#### The Vancouver Clinic

Electronic Record Delivery (Secure Portal)

Q&A

## Why is my email address needed?

This is how you will be notified when your records are ready and how to access them.

# Can I provide the email address of someone other than myself?

Yes.

#### How will I access the records?

You will receive an email from CIOX Health containing instructions for accessing the records.

## How long will I have to view the records?

You will have 30 days from when you receive email notification that the records are ready.

### What format will the records be in?

Adobe PDF Files.

# Can I print or download the records from the website?

Yes.

A fee may be associated with your request, if so, an invoice will be included with the records.