



610 NW 11<sup>th</sup> Street, Hermiston Oregon 97838  
541-667-3400

Patient Name: Med Rec#: Date of Birth: Today's Date: Or Attach Patient Label
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### PATIENT REQUEST FOR HEALTH INFORMATION

#### Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

#### What records do you want? (Check appropriate boxes below):

Date(s) of Service \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

- Discharge Summary   
  History and Physical   
  Emergency Room Report   
  Operative/Procedure Reports  
 Clinic Records  
 Test Results (X-Rays, Lab/Pathology) Please specify: \_\_\_\_\_  
 Other (Immunization Records, Medication Lists) Please specify: \_\_\_\_\_

#### How would you like your records delivered?

- Paper  
      Mail Delivery  
      In-Person Pickup  
 Electronic (Fax, E-mail, USB, CD, Other) Please specify: \_\_\_\_\_

#### Where do you want the information sent? (Fill in boxes below):

Good Shepherd Health Care System (GSHCS) should provide my records to:    Self    Personal Representative (indicate below)

Recipient Name:	Recipient Phone:
	Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

#### Please sign below:

Signature of Patient or Personal Representative	Date/Time

#### Please return completed form to:

<b>Mail:</b> Good Shepherd Health Care System/HIM Department 610 NW 11 <sup>th</sup> Street Hermiston, Oregon 97838	<b>E-mail:</b> <a href="mailto:ROIRequest@gshealth.org">ROIRequest@gshealth.org</a> <b>Fax:</b> 541-667-0193 (Hospital) or 541-303-8765 (Clinic)
	<b>Questions – please email</b> <a href="mailto:ROIRequest@gshealth.org">ROIRequest@gshealth.org</a>

GSHCS recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Rev 11/21/2025

(GSHCS USE ONLY): MRN# _____ DATE/INITIAL: _____
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