GOOD SHEPHERD
HEALTH CARE SYSTEM
610 NW 11th Street, Hermiston Oregon 97838
541-667-3621

Patient Name: Med Rec#: Date of Birth: Today's Date: Or Attach Patient Label

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:

Mail: **Good Shepherd Health Care System/HIM Department** **610 NW 11th Street** **Hermiston, Oregon 97838**	**E-mail: ROIRequest@gshealth.org** **Fax: 541-303-8765** **Questions – please email ROIRequest@gshealth.org**

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: _____

DT1000