# Member Records Request Form

Jackson Care Connect
Part of the CareOregon Family

*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: _____

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**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:<br>(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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