Records Request

Travel & Immunization Clinic of Portland
2330 NW Flanders, Ste 103, Portland, OR 97210
Phone: (503) 227-7771 Fax: (503) 227-7791

Patient Name: _____ **Date of Birth:** _____
Last *First*

Email Address: _____ **Phone number:** _____

Have you submitted an Authorization Form for Disclosure of Medical Records? Yes ☐ No ☐
If you have not, please go to our website and https://travelhealthnw.com/ under "Resources" tab, and then "Paperwork for Patients" and email it to patientrequest@travelhealthnw.com. If you are requesting vaccine receipts, you do not have to provide the disclosure form.

If you are requesting medical records, please indicate the date range: *From* _____ *to* _____
Please note: We are unable to search records for conditions such as "hernia".

If you are requesting vaccine receipts, please indicate the date range: *From* _____ *to* _____

Please note: If your medical records request includes 100 pages or less, they may be emailed to you. If more than 100 pages, they must be mailed to you. The records officer will contact you after receiving your request to let you know how many pages your request is. If you are requesting vaccine receipts, please see below under Fee Schedule.

Fee Schedule
All fees must be paid in full prior to our office sending out any medical records.

Scanning and Copying Medical Records and Vaccine Receipts: Per Page: .25 cents

Delivery: Email 1-100 pages: no fee
Mail 1+ pages: USPS Priority Flat Rate with Signature fee
Vaccine receipts, mailed: $5.00 flat fee

Please note: Records and vaccine receipts are not available for in-person pick up. Records and vaccine receipts are emailed or mailed.

Payments

Debit, Credit Cards and Money Orders are accepted
If paying by card, please call 503-228-0295 ext 115 Monday - Friday 8:30am -4:00pm
If paying by money order, please pay to the order and mail your payment to:

Travel & Immunization Clinic of Portland
P.O. Box 10006
Portland, OR 97296

Patient Signature: _____ Date: _____

or Legal Representative: _____ Relationship to Patient: _____

Please email this signed form to patientrequest@travelhealthnw.com to initiate your records request

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Office Use Only

☐ Patient name and DOB have been verified Date _____ Initials _____
☐ Patient has been informed of page count Date _____ Initials _____
☐ Patient has been informed of total fees Date _____ Initials _____
☐ Patient has agreed to fees Date _____ Initials _____
☐ Patient payment has been received Date _____ Initials _____ Emailed ___ or Mailed ____
☐ Patient records have been sent Date _____ Initials _____