Patient Request for Information Form

Fill out this form and mail to:

Patient Request for Information
Oregon Health Care Quality Corporation
520 SW 6th Ave, Suite 830
Portland, OR 97204

First, Middle, and Last Name *_____

Street _____

City, State, Zip _____

Date of Birth*_____Gender (male/female) _____

Relation to Subscriber (self, spouse, etc.)_____

* Required Fields

When I sign and mail in this form, I understand that I am choosing to receive a copy of my personal health information included in the Oregon Health Care Quality Corporation's database.

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Signature of Patient or Guardian Date