ROBERTS STREET CLINIC
FAMILY HEALTH CARE
Physicians and Surgeons

400 NE Roberts Avenue
Gresham, Oregon 97030
503-665-9144
503-666-8080 fax
www.robertsstreetclinic.com

June 20, 2025

Dear Patient,

It is with mixed emotions that we write to inform you that **Roberts Street Clinic will be permanently closing effective 9/30/2025.** This decision was not made lightly, and we understand the impact this may have on your healthcare needs.

Important Information About Your Care

Medical Records:
After closing, your health records from this Practice will be transferred to Morgan Records Management, LLC (the "Records Custodian"). The Records Custodian will continue to maintain your records in accordance with applicable confidentiality and security standards and with other applicable laws. Your records will be destroyed no less than ten years after the last date of services you received from this Practice. If you wish to have a copy of your records sent to you or to another provider or facility, you may submit a written request (see included relase form) to this office prior to 9/15/2025, or to the Records Custodian after the Effective Date. Requests to the Records Custodian, after the Effective Date should be directed to:

Morgan Records Management: Medical Records

- Online: MorganRecordsManagement.com → Request My Medical Records
- Email: Medical@MorganRM.com
- (D) 833-888-0061

Please Note:
- In accordance with applicable state law, you may be charged for the copying and transmittal of the records.
- There may be a transition period from the time we close to the time Morgan Records Management has access to charts.

If you wish to have your medical records transferred before our closing, we must receive your signed consent form (see page 2) prior to 9/15/2025. We will process only those medical record releases by closure date of 9/30/2025. If your request comes in after 9/15/2025, please see above information on where to obtain your records.

Prescriptions/Refill of Medications: ***Please plan ahead!*** You will need to refill all medications **before 8/15/2025**. After 8/15/2025 we may be able to refill a prescription, but only once and for a 30-day supply. We encourage you to find a new provider as soon as possible, to avoid any issues with prescriptions.

Please contact your pharmacy or our office before this date to ensure you have adequate medication supplies.

Our staff is available to assist with referrals thru 9/15/2025.

Timeline and Next Steps
- 8/15/2025: Last day for scheduled appointments
- 9/15/2025: Final prescription refills available
- 9/30/2025: Clinic officially closes

Contact Information
For questions about your medical records, prescription refills, or referrals, please contact us at: Phone: 503-665-9144

Please retain this letter for your records and share this information with family members who are also patients of our practice.

It has been an honor and privilege to serve as your healthcare providers. Thank you for the trust you have placed in our practice over the years. We wish you and your families continued health and wellness.

With gratitude and best wishes,
Roberts Street Clinic

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **ROBERTS STREET CLINIC (400 NE Roberts Ave, Gresham, Oregon 97030, Phone 503-665-9144, Fax 503-665-6404**), or any of its employees, staff or agents, to use and disclose protected health information (PHI) from the medical records of:

Patient Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

List Other Names Used: _____

Date(s) of Treatment: _____

Release information to:

_____

_____

Address: _____

Telephone: _____ Fax:_____

INITIAL ALL THAT APPLY:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization, Emergency Room Visit or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS)

_____ Mental health care

I am requesting the following information be released:

_____ Abstract of record (includes history & physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Billing Statements

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment

_____ Litigation for review

_____ Insurance (Company Name)

_____Other (Specify Reason)

This consent permits **Roberts Street Clinic** to use and disclose my Protected Health Information (PHI) to carry out treatment, payment or healthcare operations. Additional information regarding the uses and disclosures of PHI is described in **Roberts Street Clinic** notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment and healthcare operation purposes. However, **Roberts Street Clinic** is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE **Roberts Street Clinic**, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Patient Name (PRINT):_____ Patient Signature: _____

Signature of Legally Authorized Person (Parent/Guardian): _____

Date Signed/ Expiration Date: _____