



REQUEST TO ACCESS MEDICAL OR BILLING RECORDS

You may tear off this page and retain it for your records.

The attached form may be used to request access to your medical records. We are required to allow you to access your health information unless federal law specifically permits denial.

We usually respond to requests for access within 30 days of receiving them based on HIPAA guidelines. You may expect to receive a response or a notification of delay within that time frame. The HIPAA rule allows one (30) day extension and we must notify you of the delay and state when you can expect a response.

For more information about accessing a medical or billing record, you may contact our St. Luke's Health Information Management Department at the numbers listed below. Note, however, that requests for access must be made in writing. The Health Information Management Department will not accept requests for access over the telephone.

To submit a request for access, please complete, sign and return the attached form to:

St. Luke's Treasure Valley

190 E. Bannock
Boise, ID 83712
Phone: 208-381-2189 Fax: 208-381-2438

St. Luke's Wood River

P.O. Box 100, 100 Hospital Dr.
Ketchum, ID 83340
Phone: 208-727-8335 Fax: 208-727-8326

St. Luke's Magic Valley

801 Pole Line Road West
Twin Falls, ID 83301
Phone: 208-814-0160 Fax: 208-814-1950

St. Luke's McCall

1000 State Street
McCall, ID 83638
Phone: 208-630-2239 Fax: 208-634-4638

St. Luke's Elmore

P.O. Box 1270
Mountain Home, ID 83647
Phone: 208-587-8401 ext.105 Fax: 208-580-2682

St. Luke's Jerome

709 N. Lincoln
Jerome, ID 83338
Phone: 208-814-9790 Fax: 208-814-9595

St. Luke's Mountain States Tumor Institute

100 East Idaho Street
Boise, ID 83712
Phone: 208-381-3111 Fax: 208-381-4310

St Luke's Rehab Hospital

600 N. Robbins – 2nd Floor
Boise, ID 83703
Phone: 208-385-3258 Fax: 208-489-4055

If you have a question regarding HIPAA, please call our Compliance Line at
1-800-729-0966

REQUEST TO ACCESS MEDICAL OR BILLING RECORDS

Today's date _____

Patient's name _____ Birth date _____

Address _____ City _____ State _____ ZIP _____

Phone(s) (Cell #) _____ (Home #) _____ (Work #) _____

Other names under which patient has been treated: _____

Is this request for Workers Compensation? Yes No

To ensure you receive a copy of the records you are requesting, please specify the location(s) you were treated.
Please do not specify "All"

 Hospital Records (Specify location(s)) _____ Clinic Records (Specify location(s)) _____**Information Requested**

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Billing Information | <input type="checkbox"/> Imaging Report | <input type="checkbox"/> Problem List | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Medical Clearance |
| <input type="checkbox"/> History Physical | <input type="checkbox"/> Imaging Film | <input type="checkbox"/> Progress Note | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Substance/Drug Abuse |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Clinic Note | <input type="checkbox"/> Operative/ Procedure Report | <input type="checkbox"/> Psychological Studies | <input type="checkbox"/> Biometric Screening |
| <input type="checkbox"/> Lab/Pathology | <input type="checkbox"/> Medication List | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Wellness | <input type="checkbox"/> Immunization and/or Titers |
| <input type="checkbox"/> Breast Imaging (Mammo, Ultrasound, MRI) w/ report (CD or Film) | | | <input type="checkbox"/> Psych Evaluation/Assessment/Mental Health | |
| <input type="checkbox"/> Consultation Reports - Dr. Name: _____ | | | <input type="checkbox"/> Other: (Specify) _____ | |

This request is valid for services during the following:

Approximate service date(s) _____

(check one below)

- Records for service date listed above to current, until expiration of this form.
 Single disclosure for the date of service(s) specified above.

Please check the method of access you desire. Note: There may be a charge associated with processing your request. Paper copies: **Pick up in person (Location):** _____ **Mailed (Address):** _____ CD/DVD (password protected) Shipping address: _____ Email (Size restriction may apply): _____ MyChart View record in office (No copies) Other: _____**If you are the Patient's Personal Representative (e.g. guardian, agent, or parent of a minor) and can legally act for the patient; please fill out this section. Your status as a Personal Representative will be verified.**

Name _____ Relationship to patient _____

Address (if different from above) _____

Phone (if different than above) (Home/Cell#) _____ (Work#) _____

This request will expire one (1) year from date signed.

Signature: _____ Date: _____

FOR OFFICE USE ONLY (Verification of Identity)

Patient Identified: (describe method, initials & date) _____

Personal Representative identified (describe method & initial) _____

Release Made (method & date) _____

Workers Compensation checked (initials) _____