Office Use Only MR#

St Luke's

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

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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

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