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

☐ Billing Information ☐ Clinic Note ☐ Discharge Summary ☐ Emergency Room ☐ History Physical

☐ HIV/AIDS ☐ Imaging Film ☐ Imaging Report ☐ Immunization Record ☐ Lab/Pathology

☐ Medication List ☐ Operative/Procedure Report ☐ Problem List ☐ Progress Note

☐ Substance Abuse ☐ Psych Evaluation/Assessment/Mental Health ☐ Therapy Notes ☐ Psychological Studies

☐ Breast Imaging (Mammo, Ultrasound, MRI) w/ report (CD or Film) ☐ 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 for the costs associated with processing your request. An invoice will accompany your records.

☐ Paper copies:

☐ Pick up in person

☐ Copies mailed: Shipping address: ____________________________________________

☐ CD/DVD (password protected) Shipping address: ____________________________________________

☐ View record in office (No copies)

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) ____________________________________________