Patient Request for Bonner General Health Medical Records

Patient Information (Please Print) (Legal name as shown on Government issued photo ID)

First Name:	Middle Initial:	Last Name:
Name at Time of Treatment (if different than above):		Phone:
Date of Birth (MM/DD/YYYY):	Email required if requesting quickest access to records:	

Street Address:	City:	State:	Zip:

Reason for Request: ☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other: ______________________

What records do you want? (Check appropriate boxes below):

Date(s) of Service from _______/_______/_________ through _______/________/_________
If no timeframe indicated, we will provide the last 2 years of documentation unless otherwise instructed

☐ **Discharge Summary**	☐ **Emergency Room Reports**	☐ **Operative/Procedure Reports**	☐ **Billing Records**

☐ **Test Results** (X-rays, Lab/Pathology results) **Please specify:**

☐ **Other** (Immunization Records, Medication Lists) **Please specify:**

Clinic Records: ____ (clinic name)
☐ Provider Notes ☐ Diagnostic Testing (Radiology, laboratory, pathology) ☐ Other:___________________________

By initialing below, I specifically authorize the release of information relating to the diagnosis/treatment of:
☐ Substance Abuse ☐ Psychiatric/mental health ☐ HIV/AIDS/Sexually transmitted disease(s)
I hereby release the providing person(s)/organization(s) from all legal liability that might arise from the release of this sensitive information protected by Title 42 of the Code of Federal Regulations. **Initial _______**

In what format do you want your records and how do you want them delivered? (Check appropriate boxes below):

Select delivery method appropriate for format

☐ **Mail to my address above** ☐ **Mail to recipient below** ☐ **Call me to pick up**

Please FAX to: ( ) __________ - _________________

☐ **Email to my email address above** ☐ **Email to recipient below**

☐ **Please use above email to set up my access to the hospital medical record portal, which will provide me with updates to diagnostic testing results.**

☐ **Send TO:**

Recipient Name:	**Recipient Phone:**
Recipient Mailing Address:	**Recipient Email (if applicable):**

☐ **Obtain FROM:**

Recipient Name:	**Recipient Phone:**
Recipient Mailing Address:	**Recipient Email (if applicable):**

This request for records is made by me or my personal representative, as indicated below:

Printed name of Patient or Personal Representative	**Relationship** (please print)	
Signature of Patient or Personal Representative	**Date**	**Time**

Please return completed form to:

Bonner General Health **Health Information Department** **520 N 3rd Ave, Sandpoint, ID 83864**	**Email: MedicalRecords@bonnergeneral.org**	
	FAX: (208)263-1644	**Phone: (208)265-1041**

Bonner General Health recognizes a patient's right under HIPAA to access copies of his/her health information.
This authorization is valid for 6 months.

For Office use only: ROI #______________________ Complete date: _________________ Initials: __________