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 _____/_____/_____

☐ **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:_____

Disclose my complete health record except for the following information:

☐ **Mental Health Records** ☐ **Alcohol/drug abuse treatment records** ☐ **Genetic information**

☐ **Communicable diseases including, but not limited to, HIV and AIDS**

☐ **Other instruction** _____

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

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

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:**

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 in effect until life events occur that may impact this authorization. It is the patient's responsibility to inform BGH in writing of any life event that occurs that may impact this authorization. I understand that I have the right to revoke this authorization. I understand that the revocation will apply to information that has already been released to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation. If a licensed provider determines that the revocation is reasonably likely to cause serious harm to me or other persons, or when the revocation is not permitted by law.

For Office use only: ROI #_____ MRN # _____ ☐ ID Verified Complete date: _____ Initials: ____