Medical Record No.: _____

PATIENT REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

To access or obtain a copy of your patient records, please complete and return this form to:

Attn: Privacy Officer
1951 Bench Rd, Suite B
Pocatello, ID 83201

phone: (208) 238 - 1000
fax: (208) 238 - 0009
email: N/A

We may charge you a reasonable fee for copies of your records. We will require payment before providing the copies. Please contact us if you would like to obtain an estimate of the cost of the copies in advance.

**** To be completed by patient or personal representative:***

Date of records request: _____/_____/_____ **IMMC Provider:** _____

Patient: _____ **Date of Birth**: ____/____/____
Address: _____
_____

What are the date(s) of treatment for which you would like records?

☐ Treatment provided between ____/____/____ to ____/____/____.
☐ Treatment provided at anytime.
☐ Other:_____

What type of records would you like to obtain?

☐ Medical records (*please specify*) Obtain Records From:
- ☐ History and physical, exam notes, progress notes, etc. _____
- ☐ Consultation reports. _____
- ☐ Operative, surgical, and procedure reports _____
- ☐ Laboratory, pathology, and other test results. _____
- ☐ Diagnostic, images, films, or other recordings (e.g., x-rays, MRI scans, CT scans, photos, etc.) (Note: images, films, *photos, and other recordings are subject to higher charges*)
- ☐ Other: _____

☐ Billing and payment records
☐ Electronic copy of records identified above (identify requested format)
☐ Summary of records identified above. (Note: we may charge you for the cost of preparing the summary)
☐ Other: _____

How would you like to receive the records?

☐ Patient will review records at the PROVIDER's facility.
☐ Patient will pick up copies of records from the PROVIDER.
☐ ***Send the records to the following address*:** _____
_____
_____

☐ Other: _____

I certify that I am the patient identified above or that I am the person with legal authority to make health care decisions for the patient identified above.

Name: _____ Date: ____/____/____
Signature: _____
Telephone: _____

If personal representative, describe relationship to patient or authority: _____
_____

**** To be completed by PROVIDER personnel.***

Medical Record No.: _____

Patient Name: _____

PROVIDER must normally respond to a patient's request to access records within 30 days. A 30-day extension may be obtained with notice to the patient. Specific requirements for responding are found in 45 CFR § 164.524. PROVIDER personnel who respond to such requests should be familiar with the requirements of the regulation and PROVIDER's policy for responding to requests.

Date record request received by PROVIDER: ____/____/____
Date PROVIDER notified patient of response: ____/____/____
Date records provided: ____/____/____

☐ **Request accepted**; records provided by following means:
- ☐ Patient reviewed records at PROVIDER.
- ☐ Patient picked up copies of records at PROVIDER.
- ☐ Records sent to patient or personal representative at address indicated by patient.
- ☐ Records sent electronically to the e-mail address indicated by patient.
- ☐ Other: _____

☐ **Request denied** in whole or in part for following reason:
- ☐ Psychotherapy notes withheld.
- ☐ Requested records were not in patient's designated record set, i.e., they were outside Patient's medical or account records.
- ☐ Information in records was obtained from someone other than the patient under a promise of confidentiality.
- ☐ Providing records is reasonably likely to cause substantial harm to the patient or another person. If relying on this basis, PROVIDER must give patient the opportunity to have the decision reviewed by another provider identified by PROVIDER. *See* 45 CFR § 164.524(a)(3) and (d)(4).

If the request is denied in whole or in part, PROVIDER must do the following:

☐ Notify patient in writing of the basis of the denial, the process for submitting a complaint to the PROVIDER if the patient disagrees with the decision, and if applicable, the right to have decision reviewed by independent provider.

☐ Provide other records that are not subject to the denial to the extent requested.

☐ **PROVIDER does not maintain the requested records.** If PROVIDER knows where the records are, inform the patient where to direct the request.

PROVIDER representative responsible for responding to request:

Name: _____

Title: _____

A copy of this request will be maintained in the patient's medical record.