EASTERN IDAHO REGIONAL MEDICAL CENTER
Phone: 208-227-2801 – Toll Free: 1-866-270-2311 – Fax: 877-865-9738

Section A: This section must be completed for all Requests

Patient Name:	**Birth Date:** **Phone #:**
Provider's Name: EASTERN IDAHO REGIONAL MEDICAL CENTER	**Recipient's Name:** (write self or the name of the person who is to receive the records)
Provider's Address: Attention Medical records, ROI dept. 3100 Channing Way Idaho Falls, ID 83404	**Address 1:** **Address 2:** **City:** **State:** **Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Email ☐ Electronic Media, if available (*e.g.,* USB drive, CD/DVD, email)

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **or, Event:**

Purpose of disclosure: (Dr's appointment, insurance, personal records, etc.) If records are needed for an appointment, please include date needed.

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ Entire Medical Record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test, i.e. lab or xray reports		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _______________ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**

For children under 18 years of age: I have legal custody of this minor child ________ (please initial)

Print Name of Patient's Representative:	**Relationship to Patient:**	***Govt. Issued ID (include ID type, ID#, and exp. date)**

*To verify the identity of the requestor, a photocopy of a government issued picture ID must accompany this request

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Eastern Idaho Regional Medical Center contracts with HealthPort to process requests for copies of medical records.

A charge of $0.25 per page + applicable tax and postage is assessed on all patient requests.

To process a request for medical records, the following must be presented:

- A written request for medical records that includes all of the information outlined in our authorization form. A copy of this form is provided for your convenience.

What we will provide at no cost to you:

- Records to your physician for continuing care. Pertinent information (an abstract) for continuing care includes: transcribed reports (discharge summary, history and physical, operative or other procedure reports), pathology reports, radiology reports, lab reports, and clinic notes). Please specify on the authorization what records are needed. If records are needed immediately, the physician's office should fax in their request to 877-865-9738.

Requests for records to be sent to a third party (attorney, insurance company, etc.) can only be completed with a written request and patient authorization *directly from that party*. If you desire records for this purpose or for your own personal use, the records will be mailed to you and you may then re-disclose them to the third party. If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

Please notify me if the cost of my records exceeds $____________________

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from HealthPort.

PLEASE PRINT:

NAME: ____ PHONE #: (______)______________________________

ADDRESS: ____

CITY/STATE/ZIP: ____

SIGNATURE: ____ DATE: __________________________

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