PATIENT INFORMATION (PLEASE PRINT)			
Patient Name			
Address			
City/State/Zip			
Date of Birth	/ /	**Phone #**	

WHAT RECORDS DO YOU WANT?

I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.

☐ Summary (doctor notes, emergency room record, test results, operations)

☐ Discharge Summary ☐ Emergency Room Record ☐ Radiology Reports
☐ History/Physical ☐ Operative Report(s) ☐ Radiology Images

☐ Laboratory Reports
☐ Other

Date(s) of Service:

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

☐ Paper:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ CD:	☐ I will pick up in-person	☐ Mail To Home (address below)
☐ Email:	I would like my copy sent to me electronically via e-mail using the following e-mail address: _____ **WARNING: I understand there is a level of risk that my PHI could be read or otherwise accessed by a third party while in transit and agree to receiving my PHI by unencrypted e-mail using the e-mail address above. My signature indicates I understand and accept the risk.** _____**(Signature of patient)**	
☐ Other		

WHERE DO YOU WANT YOUR RECORDS SENT?

Portneuf Health Partners my records to: ☐ Myself My Personal Representative (indicated below):

Recipient Name		Recipient Telephone #
Recipient Street Address	Recipient City, State Zip	Recipient Fax or Email (if applicable)

Portneuf Health Partners recognizes a patient's right under HIPAA to access copies of his/her health information. ***There may be charges associated with processing a request and producing requested records.***

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to patient, if other than self
(Please attach appropriate legal documents)

Please Return Completed Form to:

HIM Department
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201
Fax: 208-239-3648

For questions about completing this form please call 208-239-1100

For Hospital Staff use:

MR/Acct #:_____ ID Verified #:_____

Processed by:_____ on:_____ via:_____

Notes:_____

Portneuf HEALTH PARTNERS

PATIENT REQUEST FOR HEALTH INFORMATION

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