



## **REQUEST TO ACCESS MEDICAL OR BILLING RECORDS**

***You may tear off this page and retain it for your records.***

The attached form may be used to request access to your medical records. We are required to allow you to access your health information unless federal law specifically permits denial.

We usually respond to requests for access within 30 days of receiving them. You may expect to receive a response or a notification of delay within that approximate time frame. If the records are off-site, however, it may take up to 60 days to respond. If it will take longer than that (not to exceed an additional 30 days), we will notify you of the delay.

For more information about accessing a medical or billing record, you may contact our Health Insurance Portability and Accountability Act (HIPAA) Contact Office in the St. Luke's Health Information Services department at (208) 381-1617. Note, however, that requests for access must be made in writing. The HIPAA Contact Office will not accept requests for access over the telephone.

To submit a request for access, please complete, sign and return the attached form to:

HIPAA Contact Office  
Health Information Services  
190 E. Bannock  
Boise, ID 83712



**REQUEST TO ACCESS MEDICAL OR BILLING RECORDS**

Today's date \_\_\_\_\_

Patient's name \_\_\_\_\_

Medical record # (if known) \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_

Describe the information that you would like to access (e.g., physician notes, recording of lab test results, x-rays, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

On what date(s) was the care that is described in the record provided? \_\_\_\_\_

\_\_\_\_\_

Please check the method of access that you desire:

In-person (e.g., you come to our offices to view the records).

Paper (or other physical) copies. Note that there will be a charge for the costs associated with processing your request. An invoice will accompany your records.

Please list shipping address:

If you are not the patient, please fill in the following:

Name \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Phone # (if different than above) (H) \_\_\_\_\_ (W) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_