



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, (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 St. Luke's Health Information Services departments at the numbers listed below. Note, however, that requests for access must be made in writing. The Health Information Department will not accept requests for access over the telephone.

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

St. Luke's Regional Medical Center

Or

St. Luke's Meridian Medical Center

Health Information Services
190 E. Bannock
Boise, ID 83712
(208) 381-2179
Fax: (208) 381-1481

Health Information Services
520 South Eagle Road
Meridian, ID 83642
(208) 706-1115
Fax: (208) 706-1186

If you have a question regarding HIPAA, please call our Compliance Line at 1-800-729-0966



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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: _____