Patient Acct: _____

Don E. McInturff, M.D.
David M. Denton, M.D.
Matthew A. Murdoch, M.D.
Brian C. Fulks, M.D.
Gentry C. Yost, M.D.

Shaun S. Summerill, M.D.
Laura M. Duty, M. D.
Elizabeth H. Parsons, M.D.
Matthew A. Stelzer, M.D.
David J. Larsen, M.D.
Alison M. McInturff, M.D.

(208) 232-1443
(208) 239-3434 Fax

1151 Hospital Way, Bldg. F.
Pocatello, Idaho 83201

Patient Request to Access / Disclose Protected Health Information

To access/obtain a copy of your patient records or to authorize disclosure at the request of the patient or patient representative, please complete and return this form to the Medical Records Clerk at the above address or fax number. We may charge you a fee for additional copies of these records. Please contact us if you would like to obtain an estimate of costs in advance.

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

Date of records request: _____

Patient: _____ Date of Birth: _____

_____ _____

I authorize _____

Contact Info: _____
to disclose this Patient's protected health information as requested below.

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

- ☐ Treatment provided between (date) _____and (date) _____.
- ☐ Other: _____

Which type of records would you like to obtain?

☐ Medical Records (please specify)
- ☐ History and physical, exam notes, progress notes, etc.
- ☐ Laboratory, Pathology, Test Results, Diagnostics, Images, etc.
- ☐ Immunizations
- ☐ Other: _____

☐ Billing and payment records for health care rendered during the relevant time period.
☐ 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: _____

Patient's Health Information is to be disclosed to: _____

How are these records to be received?

☐ Patient or Representative will pick up copies of records from the **Pocatello Children's Clinic**
☐ Mail/Fax/Securely email the records to the following: _____

_____

_____

☐ Other: _____

I understand that I have the right to revoke this authorization at any time except to the extent that the Pocatello Children's Clinic has taken action in reliance to this authorization. I understand that the Pocatello Children's Clinic may not condition the patient's health care on this authorization unless the purpose of the provider's evaluation & treatment is to obtain & disclose information to entities consistent with this authorization. The information disclosed per this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. To revoke this authorization, I must submit a written letter of revocation.

This authorization will expire on the following date or event: _____
If no specific date or event is stated, this authorization will expire one (1) year from the date of the authorization.
I certify that I am either the patient identified above or the person with legal authority to make health care decisions for the patient identified above.

Name: _____Telephone: _____

Signature: _____ Date: _____

Authority or Relationship to the Patient: _____

Maintain a copy of this request in the patient's medical record for 6 years *(01/2021)*