Account: _____

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

Shaun S. Summerill, M.D.
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(208) 232-1443
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1151 Hospital Way, Bldg. F.
Pocatello, Idaho 83201

Patient Request to Access Personal Health Information
Consentimiento para Obtener Información Personal Medica

To access or obtain a copy of your patient records, 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 / *Tiene que ser llenada por el paciente o representante personal.**
Date of request/ Fecha del requerimiento: _____
Patient/Paciente: _____
Date of Birth/Fecha de Nacimiento: _____
Entity(ies) authorized to use or disclose this information/ Entidades autorizadas a usar y divulgar informacion:

_____
_____

Entites to whom disclosure is to be made/Entidades autorizadas a recibir la informacion:

_____
_____

What are the date(s) of treatment for which you would like records?/ Cuales son las fechas de los records requeridos?

☐ Treatment provided between/ Tratamiento proveido entre _____ to/y_____
☐ Treatment provided at any time/tratamiento proveido en cualquier tiempo.
☐ Other/otro: _____

What type of records would you like to obtain?/Que clase de informacion quiere obtener?

☐ Medical Records (please specify)
  ☐ History & physical, exam notes, progress notes, etc/Historia medica,examines fisicos, notas de progreso, etc..
  ☐ Consultation Reports/Reportes de consultas.
  ☐ Laboratory/Pathology Results, Diagnostics, Images, etc/laboratorio, patologia, reultados de estudios, diagnosticos, imagines etc.
  ☐ Vacunas (todas)/Immunizations (all)
  ☐ Other/Otros
☐ Billing and payment records/Contabilidad y encuesta de pagos
☐ Electronic copy of records identified above/Copia electronica de los archivos mencionados anteriormente.

How would you like to receive the records?/Como le gustaria recibir el archivo medico?

☐ Patient or Representative will pick up copies of records from the Pocatello Children's Clinic / el paciente o un representante va a recoger copias de Pocatello Children's Clinic
☐ Send the records to the following address/ envielos a la siguiente direccion: _____
_____
☐ Other/otro: _____

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. To revoke this authorization I must submit a written letter of revocation/ Entiendo que tengo el derecho de revocar esta autorizacion en cualquier momento exepto al grado que Pocatello Childrens Clinic a tomado accion y depende de esta autorización.

This authorization will expire on the following date or event/ esta autorizacion se vencera en la siguiente fecha o acontecimiento: _____
If no specific date or event is stated, this authorization will expire one (1) year from the date of the authorization/ Si no existe fecha o acontecimiento por escrito, esta autorizacion se vencera un ano después de ser autorizada.

I certify that I am the patient identified above or that I am the person with legal authority to make health care decisions for the patient identified above. / Certifico que yo soy el paciente mencionado anteriormente o que yo soy el representante legal con autoridad de tomar decisiones medicas por el paciente mencionado anteriormente.

Name/nombre: _____Date/Fecha: _____

Signature/Firma: _____

Telephone/Telefono: _____

If a personal representative, describe relationship to patient or authority/ Si es usted un representante personal, describa su relacion al paciente o autoridad: _____

_____

Maintain a copy of this request in the patient's medical record