# Patient Request for Bonner General Hospital Medical Records

**Patient Information (Please Print)**

| First Name: | Middle Initial: | Last Name: | |
|---|---|---|---|
| Name at Time of Treatment (if different than above): | | Phone: | |
| Date of Birth (MM/DD/YYYY): | | Email required if requesting quickest access to records: | |
| Street Address: | City: | State: | Zip: |

**What records do you want? (Check appropriate boxes below):**

| **Date(s) of Service from _____/_____/_____ through _____/_____/_____** | | | |
|---|---|---|---|
| ☐ **Discharge Summary** | ☐ **Emergency Room Reports** | ☐ **Operative/Procedure Reports** | ☐**Billing Records** |
| ☐ **Test Results (X-rays, Lab/Pathology results) Please specify:** | | | |
| ☐ **Other (Immunization Records, Medication Lists) Please specify:** | | | |

**In what format do your want your records and how do you want them delivered?(Check appropriate boxes below):**

| **Select One format:** | **Select delivery method appropriate for format** | | |
|---|---|---|---|
| ☐ **Paper** | ☐ **Mail to my address above** | ☐ **Mail to recipient below** | ☐**Call me to pick up** |
| ☐ **CD/DVD** | ☐ **Mail to my address above** | ☐ **Mail to recipient below** | ☐**Call me to pick up** |
| ☐ **FAX** | **Please FAX to: ( ) _____--_____** | | |
| ☐ **Secure Email** | ☐ **Email to my email address above** | ☐ **Email to recipient below** | |

☐ **Please use above email to set up my access to the hospital medical record portal, which will provide me with updates to diagnostic testing results.**

**If I am requesting my records be sent to someone besides the patient, the recipient information is entered below.**

| **Recipient Name:** | **Recipient Phone:** |
|---|---|
| **Recipient Mailing Address:** | **Recipient Email (if applicable):** |

**This request for records is made by me or my personal representative, as indicated below:**

| | | |
|---|---|---|
| **Printed name of Patient or Personal Representative** | **Relationship (please print)** | |
| | | |
| **Signature of Patient or Personal Representative** | **Date** | **Time** |

**Please return completed form to:**

| **Bonner General Health**<br>**Health Information Department**<br>**520 N 3rd Ave, Sandpoint, ID 83864** | **Email: MedicalRecords@bonnergeneralhealth.org** | |
|---|---|---|
| | **FAX: (208)265-1644** | **Phone: (208)265-1041** |

**Bonner General Health 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.**

For Office use only: ROI #_____ Complete date: _____ Initials: _____

ROIX