

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 ____/____/____			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Room Reports	<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Test Results (X-rays, Lab/Pathology results) Please specify:			
<input type="checkbox"/> Other (Immunization Records, Medication Lists) Please specify:			

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

Select One format:	Select delivery method appropriate for format		
<input type="checkbox"/> Paper	<input type="checkbox"/> Mail to my address above	<input type="checkbox"/> Mail to recipient below	<input type="checkbox"/> Call me to pick up
<input type="checkbox"/> CD/DVD	<input type="checkbox"/> Mail to my address above	<input type="checkbox"/> Mail to recipient below	<input type="checkbox"/> Call me to pick up
<input type="checkbox"/> FAX	Please FAX to: () _____ -- _____		
<input type="checkbox"/> Secure Email	<input type="checkbox"/> Email to my email address above	<input type="checkbox"/> Email to recipient below	
<input type="checkbox"/> 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 Health Information Department 520 N 3 rd Ave, Sandpoint, ID 83864	Email: MedicalRecords@bonnergeneral.org	
	FAX: (208)263-1644	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: _____

