Monarch Health 1215 N. Michigan St., Ste B, Sandpoint, ID 83864 P: (208) 269-5578 F: (855) 538-6233

Patient Request for Medical Records

Patient Information (Please print)(Legal name as shown on Government issued photo ID):

Name: _____ Date of Birth: _____
Street Address: _____
Phone Number: _____ Email: _____

Purpose of Disclosure:
☐ Personal ☐ Legal ☐ Continuity of Care ☐ Transfer of Care ☐ Other (please specify):
_____

Please select how the information may be disclosed:
☐ Mail to My Address Above ☐ Mail to Recipient Listed Below ☐ Walk-In (In-Person Pickup) ☐ Call Me To Pickup ☐ Email to My Email Address Above ☐ Email to Recipient Listed Below
☐ Fax – Fax Number: (___) - _____ ☐ Other (specify):_____

Note: Email transmission may not be secure. By selecting this option, you acknowledge and accept any associated risks.

Information to Be Released: date(s) of service from ___/___/___ to ___/___/___
☐ Clinic Progress Notes ☐ Test Results (Laboratory/Pathology, Imaging) ☐ Vascular Studies
☐ Surgery/Procedure Notes ☐ Cardiac Studies ☐ Vascular Studies ☐ Other (please specify):
_____

Exclude the following from being released:
☐ Mental Health Records ☐ Alcohol use history and treatment records ☐ Substance abuse history and treatment records ☐ HIV/AIDS-related information ☐ Sexually transmitted disease (STD) testing and treatment records

Send To/Recipient of Information:
Name/Organization: _____
Mailing Address:_____
Phone Number: _____ Fax/Email (if applicable): _____

Obtain FROM:
Name/Organization: _____
Mailing Address:_____
Phone Number: _____ Fax/Email (if applicable): _____

Signature and Acknowledgment
Printed Name of Patient/Personal Representative: _____
Relationship To Patient (please print): _____
Signature of Patient/Patient Representative: _____
Date: _____ Time: _____

Monarch Health recognizes a patient's right under HIPAA to access copies of his/her health information. This authorization is valid until there are life events that occur in which the patient will inform us in writing of those changes. I understand I have a right to a copy of this signed authorization. I understand that I have the right to revoke this authorization at any time in writing. I understand that the revocation does not apply to information already released. I understand that my revocation may not be effective if I lack the capacity to sign the revocation. I also understand that disclosure may result in re-disclosure by the recipient, no longer protected by privacy laws. If a licensed provider determines that the revocation is reasonably likely to cause serious harm to me or other persons, or when the revocation is not permitted by law.