From: Kootenai Health
Health Information Management/Medical
Records Release of Information Department

2003 Kootenai Health Way
Coeur d' Alene, Idaho 83814
208.625.6251
Kootenaihealth.org

RE: Request for Copies of Medical Records

Thank you for your interest to obtain Medical Record Information.

To assist in your request an "Authorization for Release of Information" form is attached. Please complete the form and return it to the Release of Information Department, along with a copy of your driver's license or other legal picture identification if we don't have your signature on file. When we have received this authorization and have verified your identity we will process your request within 15 days. If you are patient requesting your hospital record, we will process this within 3 business days.

If you are signing on behalf of a patient for whom you are a legal guardian or personal representative, you must attach a copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a photocopy of the patient's death certificate.

Prior to copying your records, Kootenai Health would like you to know that there may be a charge for this service.

Type of Request	*Source*	*Delivery Method*	*Fees*	*Postage if Mailed*
Patient Request−Right to Access	Paper	Paper	1−48 pages free	None
			49 pages + $.10 per page	Actual postage
	Electronic Medical Record	CD/flashdrive	$6.50	None
	Radiology Imaging	CD/flashdrive	$6.50	None
	Electronic Medical Record & Paper	CD/flashdrive	$6.50 + $.07 per page	$2.42
	Paper	CD/flashdrive	$.07 per page	$2.42
	Electronic Medical Record	View−download−Transmit (VDT), certified API Technology, email	Free	None
Attorneys, Insurance, Subpoenas	All	All	$22.66 Base Fee, plus $1.24 per page	Actual postage
Disability Determination − Idaho	All	All	$15.00 Flat Rate	None
Healthcare Providers for Continued Care	All	All	Free	None
Idaho Workers Comepensation carriers−Employer or Insurance company, patient or patient's attorney	All	All	Free	None
Idaho Industrial Commission 2nd Copy	All	All	$19.00 + $1.00 per page	Actual postage
In−Person Inspection	Electronic Medical Record		Free	None
Third Party Directive	All	All	$22.66 Base Fee, plus $1.24 per page	Actual postage

The ability to charge for the copying of medical records, to cover the cost of labor, supplies and postage is covered under HIPAA, 45 CFR 164.524.

You may fax your request to our Release of Information Department at **(208) 625−6247**. If you have any questions regarding the processing of your request, please call us at **(208) 625−6251**, Monday through Friday 8:00 A.M. − 4:00 P.M.

Thank you.
Health Information Management

KootenaiHealth

Authorization for Release of Information

Kootenai Health – Medical Records
2003 Kootenai Health Way
Coeur d' Alene, Idaho 83814−2677
p 208.625.6251 f 208.625.6247
HIMROI@KH.org

I, the patient,_____D.O.B.,_____
authorize Kootenai Health and its Part 2 Program(s) (check appropriate boxes):

❑ **TO RELEASE INFORMATION TO** ❑ **TO OBTAIN INFORMATION FROM** ❑ **TO COMMUNICATE VERBALLY WITH**

Name: _____ Phone/Fax: _____

Address: _____ City/State/Zip:_____

Please indicate how you would like the records delivered: ☐ Pick up in Person ☐ Mail: _____
☐ Secure email (encrypted) _____ ☐ Fax: _____

INCLUDE DATE(S) OF TREATMENT TO BE DISCLOSED: _____

INFORMATION TO BE USED OR DISCLOSED:

Hospital Records

❑ Emergency Dept. Records ❑ History & Physical
❑ Operative Report ❑ Discharge Summary
❑ Progress Note ❑ Lab/Pathology Reports
❑ Radiology Reports ❑ Radiology Imaging

Miscellaneous Records

❑ SUD Counseling Notes (*no other box checked*)
❑ SUD Legal Proceeding (*no other box checked*)
❑ Psychotherapy Notes (*no other box checked*)

❑ Other (e.g., Treatment Record, Medication List): _____

Clinic Records

❑ Clinic Office Visit Date(s) of Service: _____ Clinic Location/Provider: _____
❑ Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS:

❑ Continuing Care ❑ Insurance Purposes ❑ Personal ❑ Legal Purposes

❑ At the request of the patient, or

❑ For the following purpose(s): _____

EXPIRATION:

This authorization expires on the following (choose one). If left blank, the form will automatically expire one year from the date signed.

☐ Date _____ ☐ Event _____ ☐ End of Treatment, or ☐ None

NOTE: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

PATIENT AUTHORIZATION:

Signing this authorization is voluntary. We will not withhold treatment, eligibility, or benefits if you choose not to sign.

I understand that I may revoke (cancel/withdraw) this authorization at any time, except to the extent that action based on this authorization has already been taken. To revoke this authorization, please complete the Revocation of Authorization section at the bottom of this authorization.

I acknowledge that incomplete forms cannot be processed and that there may be a cost associated with this request.

_____ _____ _____

Signature (Patient, Guardian, or Authorized Representative) **Relationship to Patient/Authority to Act** **Date**

*Please provide documentation to prove your authority to sign on behalf of the patient

A copy of this authorization will be provided to you. A photocopy, faxed copy, or scanned copy of this authorization is as valid as the original.

Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA.

42 CFR part 2 prohibits unauthorized use or disclosure of these records.

Revocation of Authorization

By signing below, I am revoking my previously signed authorization. I understand that my revocation does not affect any disclosures already made before the date of this revocation. This consent will expire upon revocation.

Signature: _____ **Date:** _____

Patient Identification - Write in or attach patient label
Name:
MRN #:
CSN #:
DOB/Sex:

KootenaiHealth

ROI - Other