# Southeastern Idaho Public Health

# Personal Medical Records Request Form

REV: 0324

## Client Information:

Last Name _____ First Name _____ M. Initial _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email _____

## Parent / Guardian Information (if not Client):

Last Name _____ First Name _____ M. Initial _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email _____

## Specific Information Requested:

- ☐ Colposcopy Results & follow-up plan
- ☐ Contraceptive Information
- ☐ History & Physical, most recent
- ☐ History & Physical, last 3 visits
- ☐ Immunization Records
- ☐ Lab Reports, most recent
- ☐ Lab Reports, last 3 visits
- ☐ Office Visit Notes, most recent
- ☐ Office Visit Notes, last 3 visits
- ☐ Pap Smear Results, most recent
- ☐ Pap Smear Results, last 3 visits

**For additional records needs, please call our Clinical Services team at 208.233.9080.**

I understand that my medical record may contain personal or sensitive information. Release of this information is voluntary and protected by law. This facility, its employees, officers, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I specifically authorize the disclosure and release of the following information to the persons/clinic indicated above in accordance with IDAPA 16.05.01 Protection and Disclosure of Department Records, Public Health Act Section 523-527. Disclosure of this information by any entity subject to HIPAA privacy regulations to a person/entity may be subject to re-disclosure by the recipient without my further authorization. I understand that I am not required to sign this document to receive services from SIPH.

- ☐ Yes ☐ No Specifically consent to authorize release of HIV/AIDS diagnosis/treatment/testing.
- ☐ Yes ☐ No Specifically consent to authorize release of sexually transmitted disease(s) diagnosis/treatment.
- ☐ Yes ☐ No Specifically consent to authorize release of drug or alcohol abuse diagnosis/treatment.
- ☐ Yes ☐ No Specifically consent to authorize release of mental or psychiatric illness diagnosis/treatment.

**Delivery options (If left blank, a paper copy will be provided):** ☐ Pick up ☐ Mailed Paper Copy ☐ Faxed Copy

## Signatures:

I have read the above and authorize the disclosure of the protected health information as stated.

Client / Guardian Signature: _____ Date: _____

Printed Name Client / Guardian: _____ Relationship to Client: _____

**Email completed form to:** medicalrecordsrequest@siph.id.gov