KootenaiHealth

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

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

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. − 4:30 P.M.

Thank you.
Health Information Management

ROIX
KOOTENAI HEALTH
Coeur d'Alene, Idaho
HIM STANDARD AND CUSTOMARY FEES
999999−071 Dev. 04/2021

KootenaiHealth

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the patient, _____ D.O.B. _____

Person or Business authorized to receive or obtain the information (check appropriate boxes):

❑ **TO RELEASE INFORMATION TO** ❑ **TO OBTAIN INFORMATION FROM** ❑ **VERBAL COMMUNICATION**

Name: _____

Address: _____

City/State/Zip: _____ Phone/Fax: _____

INCLUDE DATE(S) OF TREATMENT _____ **For Information to be disclosed (Written and/or Verbal)**

Hospital Records

❑ Emergency Dept. Records
❑ Operative Report
❑ Discharge Summary
❑ History & Physical
❑ Progress Note
❑ Lab/Pathology Reports
❑ Radiology Reports
❑ Other (please specify): _____

Clinic Records

❑ Clinic office visit Date(s) of Service: _____ Clinic location/provider: _____

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: _____

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released:

_____ Drug/Alcohol abuse/treatment & diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Mental Illness or Psychiatric diagnosis/treatment
_____ Sexually Transmitted Disease
_____ Genetic Records

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment.) I acknowledge that incomplete forms cannot be processed and that there may be a cost associated with this request.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. To revoke this authorization, I must submit my written request to the Health Information Department.

This authorization is valid until _____ OR when the following event occurs: _____(State when Kootenai Health is no longer authorized to disclose my information based on this authorization. If left blank, it will automatically expire one year from the date signed.) **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.

I understand that once this information is disclosed it may no longer be protected by federal or state regulations and may be re−disclosed by the person or organization that received the information.

I understand that I am entitled to receive a copy of this authorization upon my request. A copy, fax or scan of this form is to be considered as valid as the original.

_____ _____

Signed* (Patient, Guardian, or Authorized Representative) Date:

*Please provide documents to prove authority to sign on behalf of the patient and state relationship.

Identification Verified by HIM staff: ❑ Yes ❑ No ROI Staff Initials:_____ ❑ Mail ❑ In Person ❑ CD

Date Received: _____ Date Released: _____ #Pages: _____ Who Released: _____

Acct #: _____ MRN #: _____

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999999−071 Rev. 04/2021