Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237
425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

Request to Access PHI

This form needs to be filled out when patients request to inspect and copy PHI contained in their records.
Please return form to the address listed above or fax to: (208) 522-3017 Idaho Falls; (208) 356-4720 Rexburg

Patient name	Date of birth	Date of request

Address (street, city, state, zip code)	Telephone number

I request that Teton Radiology provide me with access to my personal health information as described below:

I request access to my personal health information covering the following dates:

I understand that Teton Radiology may charge a fee for the costs of copying and/or mailing costs associated with my request. You will receive a response within 30 days of the receipt of your request. I also understand in some circumstances according to HIPAA regulations that this request may be denied.

Signature of individual or personal representative	Date

If personal representative, please print name and include a description of authority to act for individual.

How would you like to obtain the requested information? (Please note electronically delivered information will be HIPAA compliant)

☐ I would like to inspect the requested records

☐ I would like to obtain a copy of my requested records in the following format:

- ☐ Images ☐ Reports
- ☐ Call me at the above telephone number when it is ready, and I will pick it up.
- ☐ Mail the information to the address above
- ☐ Electronically mailed (Email address: _____)

Teton Radiology Use Only

State how identification of individual was verified	Date request received	☐ Accepted ☐ Denied

If denied, reason for denial	Date response provided to individual

Signature of employee handling request	Date

Print employee name and title

Comments