IDAHO DEPARTMENT OF HEALTH & WELFARE

Request to Receive a Report of Health Information Disclosures

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name _____ Client Date of Birth _____
(First, MI, Last)

Client Home Address _____

Client Mailing Address (if different) _____

Client Telephone _____

Requestor Name (if different than client) _____

Requestor Telephone _____ Requestor Fax Number (optional) _____

Please list where you would like us to send our response to your request.

Name _____

Address _____

What time period do you want the Report of Disclosures to cover? _____

_____
(May not be for longer than 6 years from date requested.)

The first Report of Health Information Disclosures provided to you in a calendar year is free of charge. The Idaho Department of Health and Welfare may impose a reasonable, cost-based fee for each subsequent request for a report by you within the calendar year. The Department will notify you in advance of the fee and provide you with an opportunity to withdraw or modify the request for a subsequent report in order to avoid or reduce the fee.

The Department will notify you in writing if we are unable to respond to your request within 10 days.

If this request is being made by someone other than the subject of the information, please describe and provide documentation of your authority to request a report of health information disclosures for that person _____

_____

Your signature _____ **Date requested** _____

Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.

I, _____, being a Notary Public, do hereby

certify that on this day _____ of _____, 20_____, the above individual, having been first duly sworn, appeared before me and signed the foregoing document.

_____
Signature of Notary Public

Notary Public residing at _____

My commission expires on _____

For DHW Office use only
- o ID Provided _____
- o Form Complete _____

Authority:
- o Accessing own records _____
- o Documentation Attached _____
- o Not Required _____