**

Minidoka Medical Center │ RHC

1308 8th Street, Suite 1 │ Rupert, ID 83350 (208) 436-4322 Fax (208)436-1312

**Patient Demographics**

**Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will remain confidential.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street/PO Box City State Zip

Mailing Address(if different than physical) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street/PO Box City State Zip

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: Home phone Cell phone  Text  Email  Mail

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

## We will not use your email for solicitation. It is for communication purpose via portal only.

## Marital Status: Married \_ Single\_ Divorced\_ Separated \_ Widowed\_ Widowed/remarried\_ Significant other\_

If minor child list name of parent / guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guarantor date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number if different\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Parents Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact number for emergency, different phone number than already listed please**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

People who can **call and receive** patient medical information: **(for confidentiality purposes)**

**Name Relationship Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Select your primary medical provider in this office**

**\_\_\_\_Aaron Catmull, NP**

**\_\_\_Charles Clair, MD**

**\_\_\_Cameron McHan, NP**

**\_\_\_Shawna McCaffrey, NP**

**\_\_\_Brian Muir, DO**

**\_\_\_Kevin Owens, MD FACP**

**\_\_\_Margo Saunders, MD**

**\_\_\_Jeff Swenson, MD**

**\_\_\_Casie Taylor, NP**

**\_\_\_Tyson Steel, DO**

**\_\_\_Brad Wynn, DO**

**\_\_\_Becca Warnick, NP**

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_\_

Relationship to pt. \_\_\_\_\_\_\_\_\_\_SSN of insured: \_\_\_\_\_\_\_\_\_\_

Amount of deductible $\_\_\_\_\_ or Co-Pay $\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_

Relationship to pt. \_\_\_\_\_\_\_\_\_\_SSN of insured: \_\_\_\_\_\_\_\_\_\_

Amount of deductible $\_\_\_\_\_\_ or Co-Pay $\_\_\_\_\_

I request that payment of authorized Commercial Insurance/Medicaid/Medicare/Medicare supplement benefits be made either to me, or on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance, or Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE(for insurance assignment)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize release of any information concerning my (or my child’s) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent to Treat/Signature of patient or responsible party**

**version 01/2019**

Minidoka Medical Center │ RHC

1308 8th St. Ste 1 │ Rupert, ID 83350 P: 208- 436-4322 F: 208-436-1312

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

*Consent for Photograph*

I consent to allow photography of myself for identification purposes, and for purposes of improving my medical care documentation (ie: wounds, lesions, etc)..

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here

*AUTHORIZATION FOR TREATMENT*

I hereby authorize, Minidoka Medical Center, and any assistants or associates that may be designated, to perform medical and hospital care to the above named patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here

*I have received a copy of Patients Rights and Responsibilities (last page)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here

*Privacy Practices/Discrimination*

I have received/or declined copy of the Notice of Privacy Practices, and I have been provided an opportunity to review this entire document. Minidoka Memorial Hospital and Medical Center will not discriminate against a patient because of race, color, national origin, religion, ability to pay, or because a patient is covered by a program such as Medicaid or Medicare. If you feel you are a victim of discrimination you have the right to file written complaint to the Compliance Officer. Forms are available in the business office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign here

*Consent to use of answering machine and/or voicemail messaging/email*

I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures. I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Patient representative Date

version 01\_2019

**

Minidoka Medical Center │ RHC

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RESPONSIBILITY TO:***

Treat the staff with consideration, respect and dignity.

Understand that your life-style does affect your health.

Take an active part in your health care.

Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.

Observe facility rules and regulations that are for the safety and consideration of all patients and staff.

Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Report whether you understand a contemplated course of action and what is expected of you.

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RIGHT TO:***

Be treated with consideration, respect and dignity;

Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand;

Have privacy during case discussion, counseling & treatment;

Review your records in the presence of a healthcare professional;

Know the name and qualifications of staff providing your care;

Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;

Expect that all services, treatment and counseling techniques will take place with your informed consent;

Participate in referral planning;

Have access to the patient comment procedure;

Refuse to participate in research.

Have another individual present in the exam room with you, if you so desire.

version 01\_2019

**Health History**

**This is confidential information and will be used only for the purpose of your healthcare.**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Allergies to medications None □ What happens?***

|  |  |
| --- | --- |
|  |  |
|  |  |
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|  |  |

***Medications None □ Strength How many times a day do you take it?***

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**Please attach another paper if needed**

|  |  |  |
| --- | --- | --- |
| **Please describe any problems**  **you have ever had with any of the listed topics:** | USE THIS COLUMN TO DESCRIBE DETAILS OF  ***YOUR***  Current and Past Medical History | USE THIS COLUMN TO DESCRIBE DETAILS OF  **FAMILY**  Medical history |
| SKIN, HAIR, NAILS, TEETH  Do you wear dentures? Y N |  |  |
| EYES, EARS, NOSE, THROAT  Glasses Y N Hearing aid Y N |  |  |
| HEART PROBLEMS?  Have you had a heart attack? Y N  Do you have high cholesterol? Y N  High blood pressure? Y N |  | Has anyone in your family had a heart attack? Y N |
| LUNGS/BREATHING PROBLEMS? Y N |  |  |
| STOMACH PROBLEMS? Y N |  |  |
| LIVER / PANCREAS PROBLEMS? Y N |  |  |
| BOWEL PROBLEMS? Y N |  |  |
| KIDNEY PROBLEMS? Y N |  |  |
| BLADDER PROBLEMS? Y N | URINARY LEAKAGE? Y N |  |

**version 10/2018**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | Personal History Current and Past | Family Medical History |
| ARTHRITIS? /JOINT PROBLEMS? Y N |  |  |
| WEAKNESS? Y N |  |  |
| Have you ever had a stroke? Y N  Have you ever had seizures? Y N |  |  |
| ANEMIA / BLEEDING PROBLEMS? Y N |  |  |
| CANCER? Y N Type |  |  |
| DIABETES? Y N  If so, for how long?\_\_\_\_\_\_  Pills or Insulin |  |  |
| THYROID PROBLEMS? Y N |  |  |
| *Women*: How many pregnancies?\_\_  How many deliveries?\_\_\_  When was your last menstrual period?\_\_\_\_\_\_\_\_\_\_  Have you had a hysterectomy? Y N  Last pap smear? \_\_\_\_\_\_\_\_\_\_  Your last mammogram?\_\_\_\_\_\_ |  |  |
| Have you ever suffered from depression? Y N  Have you every suffered from anxiety? Y N  Other problems? |  |  |
| Previous Doctors and hospitals that have provided medical care for you:  Please list name of Doctor and city/state where they are located: |  |  |

**Previous hospitalizations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family History:***

**Father:** Living □ Deceased □ How old when he passed away and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fathers health condition/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother:** Living □ Deceased □ How old when she passed away and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mothers health condition/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Brother: \_\_\_\_\_\_ Health Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Sisters: \_\_\_\_\_\_ Health Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**version 10/2018**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Preventative***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Colonoscopy | Bone Density | Mammo | PAP | PSA | Eye Exam | Foot Exam | Rectal Exam | Dental Cleaning |
| Date |  |  |  |  |  |  |  |  |  |
| Normal |  |  |  |  |  |  |  |  |  |
| Abnormal |  |  |  |  |  |  |  |  |  |
| Due Date |  |  |  |  |  |  |  |  |  |

Surgical History and Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Social History***

**Occupation:**

Employed □ Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_ Unemployed □ Retired □ Homemaker □ Disabled □ Student □

**Marital Status:**

Married □ Single□ Divorced □ Separated □ Widowed □ Widowed but remarried □ Significant Other □

**Sexually Active:** Yes □ No □ Multiple Partners □ Birth control □ Condoms □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children \_\_\_\_\_\_ Number who are male\_\_\_\_\_\_\_ Number who are female\_\_\_\_\_\_ Miscarriage/s\_\_\_\_\_

**Activity Status:** Athletic □ Active/Fit □ Occasionally/Rarely □ Never □ Ideal body weight for you\_\_\_\_\_\_

**Tobacco Products/Nicotine:** None□ Cigarettes □ Cigars □ Smokeless/Chew □ E-cigarette/ Vape □ Currently use□ How many per day\_\_\_\_\_\_ How many years smoked\_\_\_\_\_\_\_ Quit□ Quit Date\_\_\_\_\_\_\_\_

**Alcohol Use:** None □ Daily □ Weekly □ Socially □ Rarely □ Beer □ Wine □ Hard Alcohol □

**Caffeinated Products:** Coffee□ # /day\_\_\_\_ Tea□ #/day\_\_\_\_ Soda Pop□ #/day\_\_\_\_ Energy Drink□ #/day\_\_\_\_

**Illegal Drugs:** None□ Marijuana□ Methamphetamines □ Cocaine□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Experimented with □ Currently Use □ Quit □ When did you quit\_\_\_\_\_\_\_\_ Rehabilitation □ Self Recovery □

***Mental Health History***

N/A□ Depression □ Anger Problems □ Bipolar □ Cutting □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

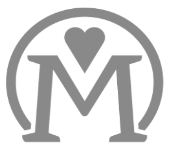
Not treated □ Treated □ If treated, Dr. name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Communicable Diseases*** NA□ Measles □ Mumps □ HIV/AIDS □ Hepatitis □ A □ B□ C□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_

***Code Status*** Full Code- all lifesaving measures □ DNR-Do not resuscitates □

**Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ version 01/2019**



REQUEST FOR PRIVATE

MEDICAL FORMATION

**Minidoka Medical Center RHC / WorkMed**

1308 8th Street Suite 1 Rupert, Idaho 83350

(P) 208.436.4322 │ (F) 208.436.1312

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Practice**

Jeffery Swenson, MD │ Brian Muir, DO │ Brad Wynn, DO │ Cameron McHan, FNP-C │Aaron Catmull, FNP-C │Casie Taylor, FNP-C Shawna McCaffrey, FNP│ Sara Zielinski, NP/ Charles Clair, MD

**Internal Medicine**

Margo Saunders, MD │ Kevin Owens, MD- FACP │ Tyson Steel, DO

**Request for Medical Records**

**Provider requesting medical/health / billing records (Circle One):**

Assume Patient Care as (PCP)  Follow patient jointly  Send my medical records  Patient request own medical records

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where to *request* records from (Hospital, Clinic, or Dr. Office/s name and number/s)**

**Name of facility and doctor/s who provided services to you:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for request:**   Labs, X-Ray, Pathology, Cultures  Medications and Immunizations  Office visit, ER, Hospital admit and discharge, Operative report, H&P  Cardiac studies, Pulmonary Function, Sleep Study  Billing Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send records via fax or ENCRYPTED email to the provided information below**

***Minidoka Medical Center, RHC***

*1308 8th Street Suite 1*

*Rupert, Idaho 83350*

*Office: (208) 436-4322 Fax: (208) 436-1312*

[*mmcrhc14@gmail.com*](mailto:mmcrhc14@gmail.com) *(this is not a secure email, you must send encrypted file)*

**Patient Signature: Today’s Date:**

If you are the patient’s parent or personal representative who can legally sign, please fill out and sign below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address, if different from patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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