



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:
(Enter Banner Facility Name)

PATIENT IDENTIFICATION	Patient Name _____		Date of Birth _____	MR # _____
	Address _____ City _____ State _____ Zip _____		Phone Number _____	
	Dates of Service: From _____		To _____	
INFORMATION REQUESTED	<input type="checkbox"/> All Pertinent Records	<input type="checkbox"/> Operative Report	Home Care/Hospice Records	
	<input type="checkbox"/> Assessment(s)	<input type="checkbox"/> Pathology Report		
	<input type="checkbox"/> Consultation	<input type="checkbox"/> X-Ray Films	<input type="checkbox"/> Nursing Assessment	<input type="checkbox"/> Plan of Care
	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Therapy Evaluation	<input type="checkbox"/> Visit Notes
	<input type="checkbox"/> ER Report	<input type="checkbox"/> Billing Record	<input type="checkbox"/> Itemized Billing Statements	<input type="checkbox"/> Specify:
	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Specify:	<input type="checkbox"/> Specify:	
	<input type="checkbox"/> History & Physical			
PURPOSE	<input type="checkbox"/> Self	<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Attorney Request	
	<input type="checkbox"/> Other (specify reason): _____			
INFORMATION TO BE SENT TO	Company, Person, Facility _____		Phone Number _____	
	Address _____		City _____	State _____ Zip Code _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner Health System will not condition or deny treatment on my signing this authorization.

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. Banner Health System's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release BHS, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: _____ **Date Sent:** _____ **Processor:** _____