Banner Health®

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

Organization Who Is Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

To Whom Information Will Be Provided	
Entity/Individual:	
Address:	
City, State	Zip Code
Fax:	Phone:

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____

Dates Requested:

FROM: _____ **TO:** _____

***There May be a FEE Associated with your Request for Records**

Records Being Requested:

Health Center/Clinic Records

- ❑ Office Visit/Progress Note
- ❑ Immunization Record
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Laboratory Report
- ❑ Medication List
- ❑ EKG Report
- ❑ Imaging/X-ray Report
- ❑ Imaging/X-ray CD/Film

_____

- ❑ Consultation
- ❑ Behavioral/Psychiatric Office visit
- ❑ Official Medical Record
- ❑ Other _____

Hospital Records (Only From Non-Banner Hospital)

- ❑ **All Pertinent Records** (includes those listed below)
  - ❑ Allergies
  - ❑ Consultation
  - ❑ Discharge Summary
  - ❑ ER Report
  - ❑ EKG Report
  - ❑ History & Physical
  - ❑ Laboratory
  - ❑ Medication List
  - ❑ Operative Report
  - ❑ Pathology Report
  - ❑ Problem List
  - ❑ X-Ray Report
- ❑ Other _____

Other Records:

❑ Billing Record ❑ Genetic Testing ❑ Photos

Further explanation of request: _____

Delivery of Records:

Paper Requests ❑ Mail ❑ Pick Up ❑ Courier ❑ Fax **Electronic Requests** ❑ E-mail ❑ CD

❑ I Do Not want my electronic record Encrypted ❑ I Do want my electronic record Encrypted

Email Address for record delivery

(Complete ONLY if requesting records via Email)

Unencrypted data sent by email can be intercepted by Unauthorized Parties

Purpose:

❑ Self ❑ Continuing Care ❑ Other (please specify): _____

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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, treatment of alcohol and/or drug abuse and genetic testing: my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner 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's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. 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 Banner Health, 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 _____ Date _____

Relationship to Patient: _____

For Healthcare Use Only		
Employee printed name who completed/reviewed form with patient:		
Verbal Release or Viewed EMR (document information/person authorized):		
Date Received:	Date Completed:	Processing Initials:
POA Verified:	ID/License#:	
Comments for CROI:		

Records picked up by: _____ Date _____

1200-0004
(03/2015)