



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

Organization Who Is Releasing Information		To Whom Information Will Be Provided	
Facility:		Entity/Individual:	
Address:		Address:	
City, State	Zip Code	City, State	Zip Code
Fax:	Phone:	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	Hospital Records (Only From Non-Banner Hospital)
	<input type="checkbox"/> Office Visit/Progress Note <input type="checkbox"/> Immunization Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Medication List <input type="checkbox"/> EKG Report <input type="checkbox"/> Imaging/X-ray Report <input type="checkbox"/> Imaging/X-ray CD/Film <input type="checkbox"/> Consultation <input type="checkbox"/> Behavioral/Psychiatric Office visit <input type="checkbox"/> Official Medical Record <input type="checkbox"/> Other _____	<input type="checkbox"/> All Pertinent Records (includes those listed below) <input type="checkbox"/> Allergies <input type="checkbox"/> Consultation <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Report <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication List <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Problem List <input type="checkbox"/> X-Ray Report <input type="checkbox"/> Other _____
	Other Records: <input type="checkbox"/> Billing Record <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Photos Further explanation of request: _____	

Delivery of Records:	Paper Requests <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Courier <input type="checkbox"/> Fax Electronic Requests <input type="checkbox"/> E-mail <input type="checkbox"/> CD <input type="checkbox"/> I <u>Do Not</u> want my electronic record Encrypted <input type="checkbox"/> I <u>Do</u> want my electronic record Encrypted NOTE: There is some level of risk that a third party could access your Protected Health Information (PHI) without your consent when electronic media or email is unencrypted. We are not responsible for unauthorized access to unencrypted media or email or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.																																							
	<table border="1" style="width: 100%; text-align: center;"> <tr><td colspan="20">Email Address for record delivery</td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <p style="text-align: center;">(Complete ONLY if requesting records via Email) *Unencrypted data sent by email can be intercepted by Unauthorized Parties*</p>	Email Address for record delivery																																						
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Purpose:	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Care <input type="checkbox"/> 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.

Yes No DO THE REQUESTED RECORDS INCLUDE DRUG/ALCOHOL TREATMENT RECEIVED: If yes, I release my drug and alcohol information for the following purpose:

_____ The information to be released should include my entire record requested except for the following: _____

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 Verified:	
Comments for CROI:		

Records picked up by: _____ Date _____