Banner Health®

Patient Name _____

Date of Birth _____

Date _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MR# _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

Dates of Service: From _____ To _____

INFORMATION REQUESTED

- ❑ All Pertinent Records (includes those listed below)
  - ❑ Consultation
  - ❑ Discharge Summary
  - ❑ ER Report
  - ❑ EKG Report
  - ❑ History & Physical
  - ❑ Laboratory
  - ❑ Operative Report
  - ❑ Pathology Report
  - ❑ X-Ray Reports
- ❑ Assessment(s)
- ❑ X-ray Image(s) _____
- ❑ Billing Record
- ❑ Photos
- ❑ Behavioral Health/Psychiatric Care Record
- ❑ Screening and/or Treatment of Alcohol and/or Substance Abuse
- ❑ Entire Official Patient Medical Record
- ❑ Specify: _____

Home Care*/*Hospice Records

- ❑ Clinical Assessment(s)
- ❑ Clinical Evaluation(s)
- ❑ Continuation Orders
- ❑ Plan of Care
- ❑ Visit Notes
- ❑ Itemized Billing Statement
- ❑ Specify: _____

PURPOSE

- ❑ Self
- ❑ Continuing Medical Care
- ❑ Other (specify reason) _____

INFORMATION TO BE GIVEN 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, 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 Health 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.

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 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 _____

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

Signature of Legal Representative _____ Relationship to Patient **or** Description of Authority to Act for Patient _____

For Healthcare Use Only

Employee completed/reviewed form with patient: _____ **ID verified:** _____

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

Records Picked Up By: _____ Date: _____