Banner Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

You can access most of your health information directly through our patient portal (Banner Health App on Android or Apple device) or mybanner.bannerhealth.com – Note: patients between the ages of 12 and 17 do not have access to the portal

Patient Information:	Patient Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ City/State: _____ Zip Code: _____

Release Information From: **Please specify facility/location, organization or individual below**		**Release/Send Information To:** **Please select one of the boxes below**	
Hospital:		❑ Self (same info as above)	
Clinic/Health Center/Urgent Care:		**OR**	
Home Care/Hospice:		❑ Entity/Individual (please specify):	
Imaging Center:			
Other:			
Address:		Address:	
City/State:	Zip Code	City/State:	Zip Code
Fax	Phone	Fax	Phone

For the Dates of Service	**FROM:** _____/_____/_____ (MM DD YYYY)	**TO:** _____/_____/_____ (MM DD YYYY)

Information to be Released:

Please Note - There may be a FEE associated with your Request for Records

❑ **All Pertinent Records:** (includes Allergies, Laboratory, Consultation, Medication list, Discharge Summary, Operative Report, ER Report, Pathology Report, EKG Report, Problem List, History & Physical, Radiology Report)

❑ **Entire Medical Record:** (includes full "designated record set" defined in 45 CFR 164.501)

Images/Photos: (Specify type of images/photos i.e. X-Ray, CT, wound photo, etc.)

❑ Radiology Images (CD): _____

❑ Other images/photos: _____

❑ **Billing Records**

❑ **Other: (please specify)** _____

_____

Specific Documents/Notes:

❑ Urgent Care Visit Notes
❑ Clinic Visit/Progress Notes
❑ Lab Reports
❑ Pathology Reports
❑ Radiology Report
❑ Genetic Testing
❑ Immunization Record
❑ Substance Abuse Notes
❑ Behavioral Health/Psychiatric Care Notes

Please **exclude** the following information from being released as part of the release of information request:

❑ Sexually Transmitted Disease
❑ HIV/AIDS
❑ Other Communicable Diseases
❑ Genetic Testing
❑ Child Abuse/Neglect Information
❑ Treatment of Substance Abuse
❑ Behavioral Health/Psychiatric Care

1200-0004
(10/2021)

1200 Use/Disclose Protected Health Info

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Delivery of Information:	**Paper Request** ❑ Mail ❑ Pick Up **Electronic Requests** ❑ E-mail ❑ CD ❑ Fax ❑ I **Do Not** want my electronic record encrypted ❑ I **Do** want my electronic record encrypted **NOTE:** There is a level of risk that a third party could access your Protected Health Information (PHI) without your consent when faxed or when electronic media or email is unencrypted. We are not responsible for unauthorized access to faxes, unencrypted media or email or for any risks (e.g., virus) potentially introduced to your computer/ device when receiving PHI in any electronic format or email. _____ **Email Address for record delivery (Complete ONLY if requesting records via email)**
Purpose:	❑ Self ❑ Continuing Care ❑ Other: _____

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 understand that 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 information and 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		
Date Received: _____	Processing Facility: _____	Processing Lawson #: _____
ID/License Verified ❑ _____	Verbal Release ❑ _____	POA Verified: ❑ _____
Additional Comments:		

Records picked up by: _____ Date _____

1200-0004
(10/2021)