Banner Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Hospital)

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:

❑ **All Pertinent Records** (includes those listed below)

❑ Allergies ❑ Laboratory
❑ Consultation ❑ Medication List
❑ Discharge Summary ❑ Operative Report
❑ ER Report ❑ Pathology Report
❑ EKG Report ❑ Problem List
❑ History & Physical ❑ Radiology Report

Non-Pertinent Records:

❑ Assessment(s) ❑ Genetic Testing
❑ Billing Record ❑ Photos
❑ Discharge Instructions
❑ Official Medical Record
(includes pertinent, non pertinent and other sections of the official medical record)

Radiology: (Specify type of test i.e. X-Ray, CT and location i.e. Shoulder, leg)

❑ Radiology CD _____ ❑ Radiology Films _____

Behavioral Health Unit/Psychiatric Record:

❑ **All Pertinent Records** (Includes those listed below)

❑ Consultation ❑ Laboratory
❑ Discharge Summary ❑ Radiology Reports
❑ History & Physical ❑ Psychiatric Evaluation
❑ Treatment Note ❑ Medication List

Non-Pertinent Records:

❑ Assessments
❑ Billing Record
❑ Discharge Instructions
❑ Official Medical Record
(includes pertinent, non pertinent and other sections of the official medical record)

Delivery of Records:

Paper Request ❑ 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

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.

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 _____

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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 _____

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(09/2017)