## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Hospital)

<table>
<thead>
<tr>
<th>Organization Who Is Releasing Information</th>
<th>To Whom Information Will Be Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility:</td>
<td>Entity/Individual:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>City, State Zip Code</td>
<td>City, State Zip Code</td>
</tr>
<tr>
<td>Fax: Phone:</td>
<td>Fax: Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Address:</td>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dates Requested:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM:</td>
<td>TO:</td>
</tr>
</tbody>
</table>

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

**Records Being Requested:**

- [ ] 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
- [ ] 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
- [ ] Discharge Summary
- [ ] EKG Report
- [ ] History & Physical
- [ ] Laboratory
- [ ] Medication List
- [ ] Operative Report
- [ ] Pathology Report
- [ ] Problem List
- [ ] Radiology Reports
- [ ] Psychiatric Evaluation

**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

**Purpose:**

- [ ] Self
- [ ] Continuing Care
- [ ] Other

*Unencrypted data sent by email can be intercepted by unauthorized parties*
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: ____________________________

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

Records picked up by: ____________________________ Date ____________