

## 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 <https://account.bannerhealth.com/>.

**NOTE:** An individual has a right to direct a healthcare provider to transmit their protected health information (PHI), maintained electronically, directly to another person or entity designated by the individual. This is considered a "third-party directive". According to federal regulations, third-party directives are only applicable to records maintained in an EHR (electronic health record) and the release must be electronic (not paper). If an individual is directing the disclosure of records that are not maintained in an EHR to a third-party, Banner Health requires a HIPAA authorization to make that disclosure.

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

<b>Release Information From:</b> Please specify facility/location, organization or individual below	<b>Release/Send Information To:</b> Please select one of the boxes below
Hospital: _____ Clinic/Health Center/Urgent Care: _____ Home Care/Hospice: _____ Imaging Center: _____ Banner Family Pharmacy: _____ Other: _____ Address: _____ City/State: _____ Zip Code: _____ Fax: _____ Phone: _____	<input type="checkbox"/> Self (same info as above) <b>OR</b> <input type="checkbox"/> Entity/Individual (please specify): _____ Address: _____ City/State: _____ Zip Code: _____ Fax: _____ Phone: _____

<b>For the Dates of Service</b>	<b>FROM:</b> ____/____/____ MM      DD      YYYY	<b>TO:</b> ____/____/____ MM      DD      YYYY									
	<i>Must be for prior or current date(s) of service. Future dates cannot be accepted.</i>										
<b>Information to be Released:</b>  <i>*Please Note- There may be a FEE associated with your Request for Records</i>	<input type="checkbox"/> Medical record abstract (e.g., History & Physical, discharge summary, operative report, consults, test results) <input type="checkbox"/> Entire Medical Record (includes full "designated record set" defined by 45 CFR 164.501) <input type="checkbox"/> Clinic/Urgent Care/home health visit notes <input type="checkbox"/> Lab/pathology results <input type="checkbox"/> Radiology/medical imaging reports (CT, MRI, x-ray, etc) <input type="checkbox"/> Immunizations <input type="checkbox"/> Home Health Clinical Assessment/evaluation <input type="checkbox"/> Home Health/hospice plan of care orders <input type="checkbox"/> Home Care/Hospice/Home Medical Equipment (Please Specify) _____ <input type="checkbox"/> Billing Records <input type="checkbox"/> Prescription Records (Banner Family Pharmacy) <input type="checkbox"/> Images/Photos (please specify) _____ <input type="checkbox"/> Other (please specify) _____										
	Please <b>exclude</b> the following information from being release as a part of the release of information request. We are not able to redact <u>specific words/phrases</u> when records are being released to the patient. <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Sexually Transmitted Disease</td> <td><input type="checkbox"/> Treatment of Substance Abuse</td> <td><input type="checkbox"/> HIV/AIDS</td> </tr> <tr> <td><input type="checkbox"/> Other Communicable Diseases</td> <td><input type="checkbox"/> Behavioral Health/Psychiatric Care</td> <td><input type="checkbox"/> Genetic Testing</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Child Abuse/Neglect Information</td> </tr> </table>		<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Treatment of Substance Abuse	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other Communicable Diseases	<input type="checkbox"/> Behavioral Health/Psychiatric Care	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Child Abuse/Neglect Information		
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<b>Delivery of Information:</b>	<b>Please select one option:</b> <b>Paper Request</b> <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <b>Electronic Requests</b> <input type="checkbox"/> Encrypted E-mail <input type="checkbox"/> Fax  <b>NOTE:</b> 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 is unencrypted. We are not responsible for unauthorized access to faxes, unencrypted media or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in any electronic format.  <div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>Email Address for record delivery (Complete ONLY if requesting records via encrypted email)</b> </div>
<b>Purpose:</b>	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Care <input type="checkbox"/> 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 only 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 or 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 <input type="checkbox"/> _____	Verbal Request- for HIMS use ONLY <input type="checkbox"/> _____	POA Verified: <input type="checkbox"/> _____
Additional Comments:		

Records picked up by: \_\_\_\_\_ Date \_\_\_\_\_