Banner Health.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize ______________________________ **to disclose the following information from the health record of:**
(Enter Banner Facility Name)

PATIENT IDENTIFICATION	Patient Name		Date of Birth	MR #
	Address		Phone Number	
	City State Zip			
	Dates of Service:	From ______	To ______	
INFORMATION REQUESTED	❑ All Pertinent Records ❑ Assessment(s) ❑ Consultation ❑ Discharge Summary ❑ ER Report ❑ EKG Report ❑ History & Physical	❑ Operative Report ❑ Pathology Report ❑ X-Ray Films ❑ X-Ray Reports ❑ Billing Record ❑ Specify:	**Home Care/Hospice Records** ❑ Nursing Assessment ❑ Plan of Care ❑ Therapy Evaluation ❑ Visit Notes ❑ Itemized Billing Statements ❑ Specify:	
PURPOSE	❑ Self ❑ Other (specify reason):	❑ Continuing Medical Care	❑ Attorney Request	
INFORMATION TO BE SENT 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, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner Health System 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 System'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 BHS, 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 Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: ______________ **Date Sent:** ______________ **Processor:** ______________