Banner
Alzheimer's Institute

2626 E. River Road
Tucson, AZ 85718
520-694-7021
www.banneralz.org

WELCOME to the Toole Family Memory Center at Banner Alzheimer's Institute (BAI)! As a Center of Excellence focused on the diagnosis, treatment, and study of Alzheimer's disease (and related disorders), we offer a comprehensive approach by an interdisciplinary team of specialists. We understand that memory and thinking problems affect both the person and the family, therefore our services target both.

STEP 1 – COMPLETE THE NEW PATIENT PACKET: Please follow the directions provided in the packet. After you've completed the packet, please print the packet and sign the "Authorization to Use or Disclose Protected Health Information" form. Then either fax the packet to our secure line (520) 694-0235, email it to us at BAITucsonMemoryClinic@bannerhealth.com. You can also mail it directly to us at the following address:

Banner Alzheimer's Institute
Toole Family Memory Center
2626 E. River Road
Tucson, AZ 85718

STEP 2 – SCHEDULING THE FIRST VISIT. We will call to schedule your visit once we have received the completed packet. Please plan to have a family member or close friend accompany you to this visit. Please make sure to bring a current medication list and glasses or hearing aids with you to all visits.

STEP 3 – FOLLOW PRESCRIBED TREATMENT PLAN: After a diagnosis is established, the physician will formulate a treatment plan. Ongoing medical needs will be addressed along with the need for education, support and community resources. Information will also be provided regarding possible participation in clinical research.

STEP 4 – ATTEND EDUCATIONAL CLASSES: You are urged to attend our complimentary education programs prior to or following the first clinic appointment: **Defining Dementia** to learn the essentials of dementia and caregiving and **Planning Ahead** to understand the important medical, legal and financial decisions that are important to address. We encourage you to take a moment to visit our website to sign up for our Beacon newsletter as well as review the full range of live and recorded education classes, support groups, life enrichment programs and resources at www.banneralz.org.

We are committed to setting a new standard of care for patients and families. We want to provide an exceptional experience – one that leaves everyone with hope and help! We look forward to seeing you and your family in the very near future.

Sincerely,

Allan A. Anderson MD

Dr. Allan A. Anderson
Director, Toole Family Memory Center

Enclosures: New Patient Packet; Authorization to Use or Disclose Protected Health Information

Banner Alzheimer's Institute

NEW PATIENT PACKET

PATIENT INFORMATION

Name (First, Middle, Last)		Age	Date of Birth (Required)
Address	City	State	Zip Code
Home Phone	Cell Phone	SSN#	
Email Address			
Emergency Contact Name:	Relationship:	Phone Number(s):	
Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner			
Primary Language(s): ☐ English ☐ Spanish ☐ Other: First language learned: ☐ English ☐ Spanish ☐ Other:			Gender ☐ Male ☐ Female
Ethnic Background: ☐ Hispanic ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Other:			

PERSON COMPLETING PACKET (IF DIFFERENT THAN ABOVE)

Name (First, Middle, Last)		Relationship to patient	
Address	City	State	Zip Code
Home Phone	Cell Phone		
Years you have known the patient	Your Age	Today's Date:	

How often do you see the patient?

☐ Every day ☐ 2 – 3 days per week ☐ 4 – 6 days per week
☐ Once every 2 weeks ☐ Once per month ☐ Less than once per month

How many hours a week do you spend with him/her?

ADDITIONAL CONTACT INFORMATION

Email address: Can we send you e-mail messages? ☐ Yes ☐ No
**All email messages will come encrypted to protect confidential patient information*

Can we contact you to set up the new patient appointment? ☐ Yes ☐ No
Your preferred method of contact? ☐ Home ☐ Cell Phone ☐ Email
If no, who should be the primary contact person:

Name (First, Middle, Last)	Relationship to patient

Which is the best method to contact the above-named person?
☐ Home: ☐ Cell: ☐ Email:

NEW PATIENT PACKET

Can we leave a message with the primary contact?

☐ YES, best method to leave a message: ☐ Home ☐ Cell Phone ☐ Email

☐ NO, don't leave a message please

POWER OF ATTORNEY

Does the patient have a durable Health Care Power of Attorney? ☐Yes ☐No

If yes, who is so named?

Does the patient have a durable Mental Health Power of Attorney? ☐Yes ☐No

If yes, who is so named?

*IF YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, **PLEASE BRING A COPY** OF THE SUPPORTING DOCUMENTS TO THE INITIAL VISIT.*

GENERAL INFORMATION

Has the patient had a consultation or work up for current symptoms? ☐Yes ☐No

If yes, please provide his/her contact information:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Does the patient have a primary care physician? ☐Yes ☐No

If yes, please provide his/her contact information:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

How did you hear about the MEMORY CENTER?

☐Friend ☐Agency ☐Physician ☐Other:

PHARMACY INFORMATION

Local Pharmacy Name	Local Pharmacy Phone
Local Pharmacy Address	

Mail Order Pharmacy Name	ID# (required)
Mail Order Pharmacy Address	

NEW PATIENT PACKET

HEALTH INSURANCE INFORMATION

PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.
MISSING INFORMATION WILL DELAY PROCESSING.

PRIMARY INSURANCE

Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	

Relationship to policy holder:

☐ Self ☐ Dependent ☐ Spouse/Partner (Member ID#:_____)

PRIMARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)

Member's insurance toll free phone number:

Insurance notification/provider's toll-free phone:

SECONDARY INSURANCE

Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	

Relationship to policy holder: ☐Self ☐Spouse/Partner (Member ID#: _____)
☐Dependent

SECONDARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)

Member's insurance toll free phone number:

Insurance notification/provider's toll-free phone:

NEW PATIENT PACKET

CURRENT PROBLEM
What is the main reason for the person's visit to the clinic?
What were the person's initial symptoms and when did they develop?
When were these initial symptoms first observed?
Did the symptoms occur suddenly or develop gradually over time? ☐ Suddenly ☐ Gradually
Have the symptoms changed over time? ☐ Stable ☐ Stable, then sudden decline ☐ Steadily worsened ☐ Fluctuating ☐ Improved
Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital) ☐ Yes ☐ No ☐ Don't Know If yes, please state the approximate year(s) and describe the event(s).

PEOPLE MAY EXPERIENCE CHANGES IN MANY ABILITIES. HELP US UNDERSTAND THE PERSON'S CURRENT ABILITIES BY MARKING THE BOXES BELOW.

MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH:	Never	Sometimes	Often	Always
Recalling recent events	☐	☐	☐	☐
Recalling details of conversations	☐	☐	☐	☐
Repeating questions or stories	☐	☐	☐	☐
Misplacing or losing items	☐	☐	☐	☐
Forgetting dates, schedules, or appointments	☐	☐	☐	☐
Recognizing familiar places, people, or objects	☐	☐	☐	☐
Recalling events from the distant past	☐	☐	☐	☐
Learning a new route to an unfamiliar place	☐	☐	☐	☐
Becoming lost or confused in familiar places	☐	☐	☐	☐
Finding words or expressing thoughts	☐	☐	☐	☐

NEW PATIENT PACKET

MEMORY & THINKING (CONTINUED)– DOES SHE/HE HAVE PROBLEMS WITH:	Never	Sometimes	Often	Always
Understanding others	☐	☐	☐	☐
Making judgments or solving problems	☐	☐	☐	☐
Carrying out multi-step activities	☐	☐	☐	☐
Multitasking (performing two tasks at one time)	☐	☐	☐	☐
Focusing, concentrating, or being easily distracted	☐	☐	☐	☐

DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH THESE ACTIVITIES (SPECIFICALLY RELATED TO CHANGES IN MEMORY & THINKING):	N/A*	Never	Sometimes	Often	Always
Medications					
Preparing/organizing medications	☐	☐	☐	☐	☐
Recalling use and/or dosage	☐	☐	☐	☐	☐
Forgetting to take medications	☐	☐	☐	☐	☐
Making other medication errors	☐	☐	☐	☐	☐
Finances					
Preparing/completing taxes	☐	☐	☐	☐	☐
Organizing/preparing bill payment	☐	☐	☐	☐	☐
Bill payment (paying late or twice)	☐	☐	☐	☐	☐
Managing checkbook/online account	☐	☐	☐	☐	☐
Calculating a tip	☐	☐	☐	☐	☐
Making change	☐	☐	☐	☐	☐
Household Tasks					
Shopping or making purchases	☐	☐	☐	☐	☐
Cooking, grilling, or preparing food	☐	☐	☐	☐	☐
Household chores or simple repairs	☐	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐	☐
Arranging transportation	☐	☐	☐	☐	☐
Using a telephone	☐	☐	☐	☐	☐
Using technology (tools, microwave, thermostat, computer, smartphone)	☐	☐	☐	☐	☐

*Please check the N/A box if the person has never performed the task(s) or you do not know.

NEW PATIENT PACKET

PERSONAL CARE AND GROOMING – HOW DOES SHE/HE COMPLETE THESE ACTIVITIES:	Completely Independent	Verbal reminders	Physical assistance	Completely Dependent
Shaving	☐	☐	☐	☐
Combing/styling hair	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Applying or removing makeup, if applicable	☐	☐	☐	☐
Bathing or showering	☐	☐	☐	☐
Dressing or undressing	☐	☐	☐	☐
Eating using utensils	☐	☐	☐	☐
Chewing and swallowing correctly/safely	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐

JUDGMENT AND SAFETY - DOES SHE/HE HAVE PROBLEMS WITH:	
☐ Leaving the stove on or microwave fires	☐ Wandering off or getting lost
☐ Leaving the water on	☐ Forgetting to eat
☐ Having trouble regulating the thermostat	☐ Living alone or being left alone
☐ Having access to weapons or power tools	☐ Being susceptible to solicitors

Does the person currently drive a motor vehicle? ☐ Yes ☐ No

If he/she drives, are you concerned about his/her safety? ☐ Yes ☐ No

If you answered "Yes" to the question above, please check any of the following areas of concern.

☐ Drives too fast	☐ Gets angry or flustered	☐ Straddles lanes
☐ Drives too slow	☐ Turns in front of other cars	☐ Runs overs curbs
☐ Gets lost	☐ Hits/scrapes objects	☐ Doesn't pay attention
☐ Recent accidents/citations	☐ Trouble parking	☐ Other:

MOOD AND BEHAVIOR: Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom(s) has been present **in the last month**.

	Not Applicable	Mild	Moderate	Severe
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	☐	☐	☐	☐
Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?	☐	☐	☐	☐
Is the patient resistive to help from others at times or hard to handle?	☐	☐	☐	☐
Does the patient seem sad, or say that he/she is depressed?	☐	☐	☐	☐
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	☐	☐	☐	☐
Does the patient appear to feel too good or act excessively happy?	☐	☐	☐	☐
Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?	☐	☐	☐	☐
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?	☐	☐	☐	☐
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	☐	☐	☐	☐
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	☐	☐	☐	☐
Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	☐	☐	☐	☐
Has the patient lost or gained weight, or had a change in the type of food he/she likes?	☐	☐	☐	☐

NEW PATIENT PACKET

PERSONALITY AND BEHAVIOR:

Please check any of the following words that describe her/his life-long PERSONALITY:

☐ Even tempered	☐ Quick tempered	☐ Optimistic	☐ Pessimistic
☐ Socially outgoing	☐ Homebody	☐ Worrier	☐ Stubborn
☐ Low self-esteem	☐ Assertive	☐ Manipulative	☐ Complainer
☐ Hypochondriac	☐ Generous/caring	☐ Good sense of humor	

Has the patient experienced any CHANGES in personality or behavior, such as:

☐ Increased impulsivity	☐ Reduced frustration tolerance	☐ Increased irritability
☐ Agitation	☐ Difficulty getting started	☐ Reduced motivation
☐ Loss of empathy	☐ Socially inappropriate behavior	☐ Restlessness
☐ Risky behaviors	☐ Social withdrawal	☐ Other, describe:

SLEEP - DOES SHE/HE HAVE PROBLEMS WITH:

☐ "Acting out dreams" while sleeping (punching or flailing arms in the air, shouting or screaming)	☐ Legs repeatedly jerking or twitching during sleep (not just when falling asleep)
☐ A restless, nervous, tingly, or creepy-crawly feeling in legs that disrupts falling/staying asleep	☐ Walking around the bedroom or house while asleep
☐ Snorting or choking him/herself awake	☐ Seem to stop breathing during sleep
☐ Increased need for sleep	☐ Excessive daytime sleepiness/drowsiness
☐ Difficulty falling asleep	☐ Difficulty staying asleep

CAREGIVER CONCERNS-IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?

Financial/legal	☐ YES	If yes, please describe
Physical health	☐ YES	If yes, please describe
Mental health	☐ YES	If yes, please describe
Managing problem behaviors	☐ YES	If yes, please describe
Decisions about alternative care options	☐ YES	If yes, please describe
Other	☐ YES	If yes, please describe

NEW PATIENT PACKET

MEDICAL HISTORY

Check below if the patient has experienced any of the following?

☐ Head trauma or brain injury ☐ Loss of consciousness ☐ Stroke or TIA (mini-stroke)
☐ Difficulty walking, falls ☐ Exposure to toxins ☐ Brain infections
☐ Seizures ☐ Other neurological condition(s): If

you checked any of the above, description(s) and date(s):

Please list any birth injuries or illnesses:

Please list any childhood/adolescent injuries or illnesses:

Any history of learning disability or ADD/ADHD? ☐Yes ☐No
Did the patient ever repeat a grade or receive special education? ☐Yes ☐No
If yes to either of these questions, please describe:

Check below if the patient has the following conditions and/or is treated for the following conditions?

☐ High blood pressure ☐ Atrial fibrillation ☐ High cholesterol ☐ Diabetes
☐ Sleep apnea ☐ Other cardiac abnormalities

Has the patient had a brain scan? ☐ Yes ☐ No	
If yes, location:	Date:
Has the patient had a neuropsychological evaluation? (usually over 2 hours of testing of thinking skills) ☐ Yes ☐ No	
If yes, by whom:	Date:

MEDICATION HISTORY

ALLERGIES

Please list allergies to medications:

Please list allergies to foods:

Please list other allergies:

NEW PATIENT PACKET

PLEASE LIST ALL MEDICATIONS TAKEN WITHIN THE LAST MONTH:

PRESCRIPTION MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

NEW PATIENT PACKET

PLEASE LIST PAST AND CURRENT MEDICAL, NEUROLOGICAL AND PSYCHIATRIC PROBLEMS

PROBLEM	DIAGNOSIS DATE	ACTIVE
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SURGICAL HISTORY		
TYPE OF SURGERY	**HOSPITAL**	**DATE**

HOSPITALIZATIONS		
REASONS FOR HOSPITALIZATION	**HOSPITAL**	**DATE**

NEW PATIENT PACKET

SYSTEM REVIEW

PLEASE REVIEW THIS AND CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS CURRENTLY EXPERIENCING

YES	CONSTITUTIONAL
☐	Chills
☐	Fatigue
☐	Fever
☐	Malaise (general discomfort)
☐	Night sweats
☐	Weight gain
☐	Weight loss

YES	HEAD, EYES, EARS, NOSE, THROAT (HEENT)
☐	Ear drainage
☐	Ear pain
☐	Eye discharge
☐	Eye pain
☐	Hearing loss
☐	Nasal drainage
☐	Sinus throat
☐	Visual changes

YES	RESPIRATORY
☐	Chronic cough
☐	Cough
☐	Known TB exposure
☐	Shortness of breath
☐	Wheezing
☐	Asthma

YES	CARDIOVASCULAR
☐	Chest pain
☐	Leg pain with walking
☐	Edema
☐	Palpitations (abnormal heart beats)

YES	GASTRO-INTESTINAL
☐	Abdominal pain
☐	Blood in stools
☐	Change in stools
☐	Constipation
☐	Diarrhea
☐	Heartburn
☐	Loss of appetite
☐	Nausea
☐	Vomiting

YES	GENITOURINARY
☐	Dribbling
☐	Burning with urination
☐	Blood in urine
☐	Excessive urination
☐	Slow stream
☐	Urinary frequency
☐	Urinary incontinence
☐	Urinary retention

YES	REPRODUCTIVE
☐	Erectile dysfunction (men)
☐	Penile/vaginal discharge
☐	Sexual Dysfunction
☐	Abnormal Pap smear (women)
☐	Breast discharge or lump (women)
☐	Painful menstrual periods (women)
☐	Pain with intercourse
☐	Hot flashes (women)
☐	Irregular menstrual periods (women)

YES	METABOLIC/ENDO
☐	Brittle hair
☐	Brittle nails
☐	Cold intolerance
☐	Hair changes
☐	Heat intolerance
☐	Excessive hair growth
☐	Excessive thirst
☐	Excessive eating

YES	NEUROLOGICAL
☐	Dizziness
☐	Extremity numbness
☐	Extremity weakness
☐	Walking or balance problems
☐	Headache
☐	Memory loss
☐	Seizures/convulsions
☐	Tremors
☐	Sudden loss of consciousness

YES	PSYCHIATRIC
☐	Anxiety
☐	Depression
☐	Insomnia

YES	SKIN
☐	Contact allergy
☐	Hives
☐	Itching
☐	Mole changes
☐	Rash
☐	Skin lesion

YES	MUSCULO-SKELETAL
☐	Back pain
☐	Joint pain
☐	Joint swelling
☐	Muscle weakness
☐	Neck pain

YES	HEMOTOLOGIC/ LYMPHATIC
☐	Easy bleeding
☐	Easy bruising
☐	Swollen glands

YES	IMMUNOLOGIC
☐	Environmental allergy
☐	Food allergy
☐	Seasonal allergy

PHYSICIAN NOTES

NEW PATIENT PACKET

SOCIAL HISTORY

Highest level of formal education completed:

☐ Less than high school ☐ GED ☐ High school
☐ Some college ☐ Associate degree ☐ Bachelor's degree
☐ Master's degree ☐ Doctoral degree

Retired: ☐Yes ☐No If yes, year retired:

If working, current occupation:	If no longer working, prior occupation:
Years in current occupation: Currently working: ☐ Part-time ☐ Full-time	Years in occupation: Worked: ☐ Part-time ☐ Full-time

Hobbies/Interests

Does/did memory and thinking problems affect(ed) working or hobbies? ☐ Yes ☐ No

Number of living children: Number of daughters: Number of sons:

Current living situation:

☐ Alone in home/apt ☐ With spouse/significant other ☐ With other family or friends
☐ Assisted living ☐ Nursing home ☐ Other:

SUBSTANCE USE HISTORY

TOBACCO USE

Does the patient currently smoke? ☐ Yes ☐ No

If yes: # of packs per day:	# of years smoked:
Did the patient ever smoke in the past? ☐ Yes ☐ No	If yes, year quit:
If patient ever smoked, # of packs per day:	# of years smoked:

ALCOHOL USE

Current use: How many drinks per week?

Past use: How many drinks per week?

Any history of excess use (now or in the past)? ☐ Yes ☐ No

SUBSTANCE USE

Has the patient used medical marijuana, recreational drugs, and/or misused prescription medications recently and/or in the past? ☐ Yes ☐ No

If yes:	Type:	Duration:

NEW PATIENT PACKET

FAMILY HISTORY

DOES THE PATIENT HAVE A BLOOD RELATIVE WITH SYMPTOMS OF OR DIAGNOSIS OF:

Dementia/Senility/Alzheimer's? ☐ Yes ☐ No If yes, relationship and age of onset of memory problems:		
Parkinson's disease? ☐ Yes ☐ No		If yes, relationship:
Strokes? ☐ Yes ☐ No		If yes, relationship:
Psychiatric/Mental Illness? ☐ Yes ☐ No		If yes, relationship:
Intellectual disability? ☐ Yes ☐ No		If yes, relationship:
How many brothers: How many sisters:		
Does the patient have living siblings without dementia? ☐ Yes ☐ No		
Please list diseases/illnesses in your family:		
Mother:		
Father:		
Siblings: • Brothers: • Sisters:		
Children:		
Grandparents: • Mother's side: • Father's side:		

Banner Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

Organization Who Is Releasing Information	
Facility:	
Address:	
City, State	Zip Code
Fax:	Phone:

To Whom Information Will Be Provided	
Entity/Individual: Banner Alzheimer's Institute Tucson	
Address: 2626 E. River Road	
City, State: Tucson, AZ	Zip Code: 85718
Fax: 520-694-0235	Phone: 520-694-7021

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:	Health Center/Clinic Records ❑ Office Visit/Progress Note ❑ Immunization Record ❑ Operative Report ❑ Pathology Report ❑ Laboratory Report ❑ Medication List ❑ EKG Report ❑ Imaging/X-ray Report ❑ Imaging/X-ray CD/Film _____ ❑ Consultation ❑ Behavioral/Psychiatric Office visit ❑ Official Medical Record ❑ Other _____	Hospital Records (Only From Non-Banner Hospital) ❑ **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 ❑ X-Ray Report ❑ Other _____
	Other Records: ❑ Billing Record ❑ Genetic Testing ❑ Photos Further explanation of request: _____	
Delivery of Records:	**Paper Requests** ❑ 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 (please specify): _____	

1200 HIMS/ROI

1200-0004 (09/2017)

Banner Health®

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

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.

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 _____