Big Thompson Medical Group, Inc.
Medical Release Form

* Starred items are required for completion of your request.

Release Medical Records From:	Release Medical Records To:
*Doctor/Hospital	*Name of Company/Agency/Facility/Person
*Street Address	*Street Address
*City, State, Zip Code	*City, State, Zip Code
*Phone Number **Fax**	*Phone Number **Fax**

Patient Information:

*Print Patient's Full Name	*Date of Birth (month/day/year)
*Street Address	*City, State, Zip Code
*Daytime Phone Number	Alt Phone Number

Information to be released:

*Release the following records:

____ 2 yrs medical records _____

____ Specific records: _____

____ Other _____

*Purpose of Discloser

___Referral to Specialist ___Permanent Transfer ___Personal ___Insurance
___Workers Comp ___Legal Investigation ___Disability Determination ___Other

*There will be a charge for a **personal** copy of your records. Smart Document Solutions has been contracted to provide this service and will invoice you.

*This authorization is valid from 6 months from date of signature unless otherwise indicated: _____

- 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 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, 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.

*Patient or legally authorized individual signature * Date

*Printed name of person signing release relationship (self/parent/legal guardian/personal rep)

Big Thompson Medial Group Witness