Banner Health

HEALTH INFORMATION REQUEST FORM

Please complete and return this form to your healthcare provider

Patients have the right to request a copy of their health information through the State/Regional/CommonWell Health Information Exchange (HIE). Patients also have a right to request a list of the persons who have accessed their health information through the HIE in the last three years.

If you want to request any of this information, please complete and return this form to your healthcare provider. You will receive a response to the request within 30 days. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Patient Name: _____ **Date of Birth:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Please check all boxes that apply:

☐ I request a copy of all my health information that is available through the HIE.

☐ I request a list of all persons who have viewed my health information through the HIE in the past three years. I understand that this list will not include persons who viewed my health information in other ways, such as through a healthcare provider's electronic health record.

Signature of Patient or Patient's Parent/Guardian/Healthcare Decision Maker: _____

Print Name: _____ **Date:** _____

If signed by a person other than the parent, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

---

Provider Office Only: *Please complete before sending via secure fax or secure email to the HIE.*

Print Name: _____ Date: _____

Signature: _____