Banner
Alzheimer's
Institute

901 East Willetta Street
Phoenix, AZ 85006
602-839-6900
www.banneralz.org

**WELCOME** to the Stead 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 (602) 839-6906 or mail it directly to us at the following address:

Banner Alzheimer's Institute
Stead Family Memory Center
901 East Willetta Street
Phoenix, AZ 85006

**STEP 2 – SCHEDULING THE FIRST VISIT.** We will call to schedule your visit, once we have received the completed packet. Please plan for a 90 minute visit with our dementia specialty team.

**STEP 3 – FOLLOW PRESCRIBED TREATMENT PLAN**: After a diagnosis is established, the physician will formulate a treatment plan. The 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 two free classes prior to or following the first clinic appointment: COMPASS, a 90-minute class to learn the essentials of dementia and caregiving; and Planning Ahead, a 2-hour class to understand the important medical, legal and financial decisions that must be addressed. For a full list of education/support programs visit the website at www.banneralz.org and click on "Event Calendar."

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,

Dr. William J. Burke, M.D.
Director, Stead 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) | | Date of Birth (Required) | |
| Address | City | State | Zip Code |
| Home Phone | Cell Phone | SSN# | |
| Email Address | | | |
| Relationship Status<br>☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Partner | | | |
| Primary Language<br>☐ English ☐ Spanish ☐ Other: | | Gender<br>☐ Male ☐ Female | |
| Ethnic Background: ☐ Hispanic ☐ Caucasian ☐ African American<br>☐ 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?<br>☐ Every day ☐ 2 – 3 days per week ☐ 4 – 6 days per week<br>☐ Once every 2 weeks ☐ Once per month ☐ Less than once per month<br>How many hours a week do you spend with him/her? | | | |
| Email address: | | | |
| Can we send you e-mail messages? ☐ Yes ☐ No<br>All email messages will come encrypted to protect confidential patient information | | | |

| | | |
|---|---|---|
| Can we contact you to set up the new patient appointment? ☐ Yes ☐ No<br>Your Preferred method of contact? ☐ Home ☐ Cell Phone ☐ Email<br>If no, who should we contact? | | |
| Name (First, Middle, Last) | Relationship to patient | |

Banner Alzheimer's Institute

# NEW PATIENT PACKET

Which is the best method to contact the above named person?
☐Home ☐Cell ☐Email:
Can we leave a message?
☐ YES best method to leave a message ☐Home ☐Cell Phone ☐Email
☐NO don't leave a message please

Dose the patient have a durable Health Care Power of Attorney? ☐ Yes ☐No
If yes, who is so named? Please provide a copy

Dose the patient have a durable Mental Health Power of Attorney? ☐ Yes ☐No
If yes, who is so named? Please provide a copy

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

## GENERAL INFORMATION

Has the patient had a consultation and work up for current symptoms? ☐ Yes ☐No
If yes, please provide their contact information:

| Physician Name: | Phone Number |
|---|---|
| How long have you been seeing this physician? | Fax Number |

Does the patient have a primary care physician? ☐ Yes ☐No
If yes, please provide their contact information:

| Physician Name: | Phone Number |
|---|---|
| How long have you 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 | |

Banner Alzheimer's Institute

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

| 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: |

| FOR OFFICE USE ONLY |
|---|
| |

Banner Alzheimer's Institute

# NEW PATIENT PACKET

| CURRENT PROBLEM |
|---|
| What is the main reason for the person's visit to the clinic? |
| Is the person aware of why they will be coming to the clinic? ☐ Yes ☐ No |
| 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 |
| 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)<br>☐ Yes ☐ No ☐ Don't Know<br>If you answered 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.**

| 1. MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH: | Never | Sometimes | Often | Always |
|---|---|---|---|---|
| Recalling recent events | ☐ | ☐ | ☐ | ☐ |
| Repeating questions or stories | ☐ | ☐ | ☐ | ☐ |
| Misplacing items | ☐ | ☐ | ☐ | ☐ |
| Forgetting dates or appointments | ☐ | ☐ | ☐ | ☐ |
| Speaking or understanding | ☐ | ☐ | ☐ | ☐ |
| Giving up or withdrawing from activities | ☐ | ☐ | ☐ | ☐ |
| Recognizing familiar places, people, or objects | ☐ | ☐ | ☐ | ☐ |
| Recalling events in the past | ☐ | ☐ | ☐ | ☐ |

Banner Alzheimer's Institute

# NEW PATIENT PACKET

## 2. DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH:

| | Never | Sometimes | Often | Always |
|---|---|---|---|---|
| Using the telephone | ☐ | ☐ | ☐ | ☐ |
| Shopping | ☐ | ☐ | ☐ | ☐ |
| Preparing food | ☐ | ☐ | ☐ | ☐ |
| Housekeeping | ☐ | ☐ | ☐ | ☐ |
| Doing laundry | ☐ | ☐ | ☐ | ☐ |
| Driving or arranging for transportation | ☐ | ☐ | ☐ | ☐ |
| Taking medications | ☐ | ☐ | ☐ | ☐ |
| Handling money | ☐ | ☐ | ☐ | ☐ |
| Using technology (tools, microwave, computer, thermostat, etc.) | ☐ | ☐ | ☐ | ☐ |
| Walking<br>Have they had falls? ☐ Yes ☐ No | ☐ | ☐ | ☐ | ☐ |

## 3. PERSONAL CARE AND GROOMING – DOES SHE/HE HAVE PROBLEMS WITH:

| | 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 | ☐ | ☐ | ☐ | ☐ |

**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? | ☐ | ☐ | ☐ | ☐ |

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 her/his personality changed? If so, in what way?

| 4. SLEEP - DOES SHE/HE HAVE PROBLEMS WITH: | |
|---|---|
| ☐ "acting out his/her 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 his/her legs that disrupts his/her ability to fall or stay asleep | ☐ walking around the bedroom or house while asleep |
| ☐ snorting or choking him/herself awake | ☐ seem to stop breathing during sleep |

| 5. 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 | ☐ Making medication errors |
| ☐ Having trouble regulating the thermostat | ☐ Living alone or being left alone |
| ☐ Having access to weapons | ☐ 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 objects | ☐ Doesn't pay attention |
| ☐ Others: | | |

Banner Alzheimer's Institute

# NEW PATIENT PACKET

**WE RECOGNIZE THAT THESE CONDITIONS HAVE A DIRECT IMPACT ON FAMILY CAREGIVERS. IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?**

| Caregiver Concerns | | |
|---|---|---|
| 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 |

| MEDICAL HISTORY |
|---|
| Please list any birth injuries or illnesses: |
| Please list any childhood and adolescent injuries or illnesses: |

| Has the patient had a brain scan? | ☐ Yes | ☐ No |
|---|---|---|
| If yes, location: | Date: | |

| Has the patient had a stroke? | ☐ Yes | ☐ No |
|---|---|---|
| If yes, date(s): | | |

***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/HOSPITALIZATION HISTORY | | |
|---|---|---|
| **REASON FOR HOSPITALIZATION** | **HOSPITAL** | **DATE** |
| | | |
| | | |
| | | |
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Banner Alzheimer's Institute

# NEW PATIENT PACKET

## SYSTEM REVIEW

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

| YES | CONSTITUTIONAL |
|---|---|
| ☐ | Chills |
| ☐ | Fatigue |
| ☐ | Fever |
| ☐ | Malaise (general discomfort) |
| ☐ | Night Sweats |
| ☐ | Weight Gain |
| ☐ | Weight Loss |

| YES | HEENT (HEAD, EYES, EARS, NOSE, THROAT) |
|---|---|
| ☐ | 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 |
|---|
| |

Banner Alzheimer's Institute

# NEW PATIENT PACKET

| MEDICATION HISTORY |
|---|
| **ALLERGIES** |
| Please list allergies to medications: |
| Please list allergies to foods: |
| Please list other allergies: |

**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** |
| | | | | | |
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| NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS MEDICATIONS | | | | | |
|---|---|---|---|---|---|
| **DRUG NAME** | **DOSE** | **TIMES PER DAY** | **DATE STARTED** | **DATE STOPPED** | **MEDICAL CONDITION BEING TREATED** |
| | | | | | |
| | | | | | |
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| | | | | | |
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# NEW PATIENT PACKET

| SOCIAL HISTORY | |
|---|---|
| Years of education completed: | |
| Previous or current occupation: | Years in occupation: |
| Hobbies/Interests | |
| Number of living children: | |
| Current living situation:<br>☐ Alone in home/apt ☐ With spouse/family/friend ☐ Assisted Living<br>☐ Nursing home ☐ Other: | |

## SUBSTANCE USE HISTORY

| ALCOHOL USE | | | |
|---|---|---|---|
| Has the patient ever used alcohol excessively? | | ☐ Yes | ☐ No |
| Current use: How many drinks per week? | | | |
| Past use: How many drinks per week? | | | |

| TOBACCO USE | | | |
|---|---|---|---|
| Does the patient currently smoke? | | ☐ Yes | ☐ No |
| If no, date of cessation: | | | |
| If patient ever smoked: | # of packs per day: | # of years smoked: | |

| SUBSTANCE USE | | | |
|---|---|---|---|
| Has the patient ever misused legal or illegal substances? | | ☐ Yes | ☐ No |
| If yes: | Type: | Duration: | |

| FOR OFFICE USE ONLY |
|---|
| |

Banner Alzheimer's Institute

# 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: |
| Parkinson's? | ☐ Yes | ☐ No | If yes, relationship: |
| Strokes? | ☐ Yes | ☐ No | If yes, relationship: |
| Psychiatric/Mental Illness? | ☐ Yes | ☐ No | If yes, relationship: |
| Mental Retardation? | ☐ Yes | ☐ No | If yes, relationship: |
| Does the patient have living siblings without Dementia? | ☐ Yes | ☐ No | |
| Please list diseases/illnesses in the immediate family: | | | |
| Father: | | | |
| Mother: | | | |
| Sibling #1: | | | |
| Sibling #2: | | | |
| Sibling #3: | | | |
| Sibling #4: | | | |

## FOR OFFICE USE ONLY

I have reviewed the patient packet in its entirety.

Physician Initials: _____ Date: _____

Banner Health

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label

**I authorize** _____ **to disclose the following information from the health record of:**
**(Health Center/Clinic or Physician Name)**

**PATIENT INFORMATION**

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

**Dates of Service being Requested:**
From: _____ To: _____

**Clinic/ Health Center**
- ☐ Office Visit/Progress notes
- ☐ Immunization Record
- ☐ Radiology/Diagnostic Testing
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Medication List
- ☐ EKG Report
- ☐ Consults

☐ Behavior/Psychiatric Office Visits

***There may be a FEE associated with a records request.***

**Delivery of records by:** ☐ Paper Request ☐ Mail Pick Up **AND OR Electronic Request**: ☐ Email ☐ CD

Email Address for record delivery

(Complete ONLY is requesting records via Email)

☐ I Do NOT want my electronic record Encrypted ☐ I Do want my electronic record Encrypted

**Unencrypted data sent by email can be intercepted by unauthorized parties**

**Purpose**

☐ Self ☐ Continuing Medical Care ☐ Other (Specify Reason): _____

**Information to be Picked Up by or Mailed to:**

Company, Person, Facility: Banner Alzheimer's Institute Phone Number : 602-839-6900 fax:602-839-6906

Address: 901 E Willetta St City: Phoenix State: AZ Zip: 852006

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 and genetic testing; 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.

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 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.

X _____ _____

Signature of Patient Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____

Signature of Legal Representative Relationship to Patient of
Description of Authority to Act for Patient

**For Healthcare Use Only**

Employee completed/reviewed from with patient: _____ Requestor/Patient Representative ID#: _____

Verbal Release of View EMR (Document information/person) authorized: _____

Date Received: _____ Date Sent: _____ Processor: _____

POA Verified: _____

*1200* HIMS/ROI

Records Picked Up By: _____ Date: _____

1200
(08/2013)