Basin Clinic Inc.

421 W. Adams St PO Box 340 Naturita, CO 81422

970-865-2665 ph 970-865-2674 fx

Providing Quality Health Care

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____
(Last, First, Middle)

Address_____ Date of Birth_____

City/State/Zip Code_____SS#_____

Telephone Number_____ Mother's Maiden Name/ Other Name:

Date of Request_____ _____

I authorize Basin Clinic to release information to:

Name of Provider Organization/Person:_____

Address:_____

Phone Number:_____**Fax Number**_____

I authorize Basin Clinic to obtain information from:

Provider Name/Organization:_____

Address:_____

Phone Number:_____Fax Number:_____

Purpose of Request for Information: Healthcare Insurance Coverage Personal Other _____

Information to be Released: (check all applicable boxes and initial selection as required.)

____(Initial) All my health information pertaining to any medical history, physical condition and treatment received. OR, only the following records or types of health information and /or only on the specified date(s):

Date(s) of Treatment: _____ Type of Treatment:_____
(Inpatient, Emergency Dept. Outpatient, Other)

( ) Discharge Summary	( ) Emergency Room Records	( ) Radiology Reports	( ) Medication Records
( ) History & Physical	( ) Pathology Report	( ) EKG Reports	( ) Nursing Notes
( ) Operative Report	( ) Laboratory Report	( ) Physician Orders	( ) Radiology Film
( ) Consultation			

_____(Initial) Other: _____

_____(Initial) Records of treatment for psychiatric or mental health illness

_____(Initial) Records of treatment for drug or alcohol abuse

_____(Initial) HIV test results or records of the diagnosis or treatment for HIV, HIV-related illness, AIDS, or AIDS-related

I UNDERSTAND THAT:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the Medical Records Department address provided on page 1 of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by the privacy regulations, the information stated above may be re-disclosed.
- A recipient of medical information in Colorado may not further disclose medical information about me (patient) unless a new authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

Basin Clinic Medical Records, photocopies patient records in accordance with the Colorado Health and Safety Code and HIPPA regulations. Charging for the processing of photocopies of patient records is permitted and invoices will be sent directly. Charges for photocopies are available at the Front Office.

NOTE: Medical records are faxed in cases of medical necessity only.

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End Date:_____ **or Event Name:**_____

_____ _____

Signature of patient (or personal representative, if applicable) **Date**

_____ _____

Print name of personal representative (if applicable) (Legal representative, parent, guardian, spouse) **Relationship to patient (If other than patient, describe relationship to pt.**

_____ _____

Address **Witness**

_____ _____

Phone No. **Type of ID presented. Attach copy**

COPY RECEIVED: I Acknowledge receipt of a signed copy of this authorization. _____ **Initials**

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITTED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

Records are to be: Mailed _____
Or Picked up by Patient or Patient Representative