Basin Clinic
Request/ Release of Medical Records

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Phone: (435)789-1165
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I authorize Basin Clinic to: (please check one)
_____Release Medical Records to: ______Request Medial Records From:

____
Name of Physician / Organization

____
Complete Address (**REQUIRED**)

____
Reason for Request

Record Dates for Copying ________________________________

I understand my rights under HIPPA guidelines, and theat the information to be released may contain information regarding:

*Drug or Alcohol Abuse, if any.
*Psychologicical or Psychiatric Conditions, , if any.
*A Diagnosis for or other reference to Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may be charged for records copied.
By signing I free providers of Basin Clinic from any legal liability that my arise from the release of information.
This authorization is valid for 60 days from the date signed.

______________________________ ____________ ____________
Name of Patient(s)   Social Security #   Birth Date

____
Patient's Address   Phone #

____
Signature of Patient or Guardian   Relationship   Date

____
Witness Signature   Date