Request/Release of Medical Records
379 North 500 West, Suite 1A
Vernal, UT 84078
Phone: 435-789-1165
Fax: 435-789-1169

I Authorize Basin Clinic to: (Please check one)
Release Medical Records to:_______
Request Medical Records from:______

____
Name of Physician/Organization

____
Complete Address or Phone/Fax Number (REQUIRED)

____
Reason for Request

Record Dates for Copying ______________________________________

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

*Drug or Alcohol Abuse, if any.
*Psychological 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 may arise from the release of information.
This authorization is valid for 60 days from the date signed.

Name of Patient | Social Security # | Birth Date

Patient's Address | Phone #

Signature of Patient or Gaurdian | Relationship | Date

Witness Signature | Date