HIPAA CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Basin Immediate Care to use and disclose the health and medical information of: _____ for the purpose of **Treatment, Payment and Health Care Operations.***
(name of patient)

***Treatment** (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other health care providers.

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health care benefit claims, and utilization management activities which include review of health care services for medical necessity, justification of charges, precertification and preauthorization.)

***Health care operations** (includes the necessary administrative and business functions of our office.)

You may review Basin Immediate Care's ***"Notice of Privacy Practices"*** for additional information about the uses and disclosures of information described in the **CONSENT** prior to signing the **CONSENT**. Please verify that you have received a copy of our ***Notice*** by placing your initials here: [ ]

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the ***Notice*** may also change. The ***Notice*** will be posted in the reception room of our office indicating the effective date of the ***Notice*** in the upper right hand corner. We will offer you a copy of the ***Notice*** on your first visit to us after the effective date of the then current ***Notice***.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your protected health information (PHI) for treatment, payment, and health care operations purposes.

WE ARE NOT REQUIRED TO AGREE WITH YOUR REQUEST.

If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Basin Immediate Care has already used or disclosed the information in reliance on this CONSENT.

_____ _____
Date Signature of patient

_____ _____
Date Signature of person authorized by law

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