Elizabeth Bassow-Scheve, MD, PC
Family and General Medicine

Lisa M. Bassow-Scheve, MD Kristin L. Moreau, MD Holly L. Elgas, MD Sean D. Flannery, PA-C

Authorization for Use and Disclosure of Protected Health Information

Please be sure to complete the form thouroghly. Delays may occur with illegible or incomplete requests.

Patient's Name _____ Date of Birth:_____

I authorize my physician and staff to disclose the following health information (check one):

_____ Entire Chart

_____ Specific Information (please specify):_____

Records: [ ] To: [ ] From:	Records: [ ] To: [ ] From:
_____	Elizabeth Bassow-Scheve, MD, PC
_____	Family and General Medicine
_____	4045 Wadsworth Blvd, Suite 250
_____	Wheat Ridge, Colorado 80033
Phone: (_____)_____	Phone: (303) 425-6012
Fax: (_____)_____	Fax: (303) 467-9211

This protected health information is being disclosed and used for the following purpose (check one):

- ❑ Changing to a new provider
- ❑ Seeing a specialist
- ❑ Continuing care
- ❑ At the request of the individual
- ❑ Litigation
- ❑ Other (please specify): _____

This authorization shall be in effect for one year or until (date) _____. I understand that I have the right to revoke this authorization, in writing, at any time.

_____ _____
Signature of Patient/Guardian/Representative Printed Name of Patient/Guardian/Representative

_____ _____
Date Relationship