HIPPA RELEASE OF MEDICAL INFORMATION AUTHORIZATION

1. I, ______________________________ [*print name*] hereby authorize Northwest Fire District and its affiliates, employees and agents [collectively, "Northwest Fire District"] to release to ____ [*insert name of person or organization*] my protected health information (''PHI'') described below for the purpose of helping me to resolve claims, obtain insurance coverage or for such other purposes as I may direct.

2. Authorization for release of PHI covering the period of health care (check one)
a. ___ From (date) _________________ - to (date) ______________________ **OR**
b. ___ All past, present and future periods.

3. I hereby authorize the release of PHI as follows (*check one*):
a. ___ My complete health record (including information regarding my billing, condition, treatment and prognosis, and records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). **OR**
b. ___ My complete health record, with the exception of the following information (*check as appropriate*):
___ Mental health records
___ Communicable diseases (including HIV and AIDS)
___ Alcohol/drug abuse treatment
___ Other (please specify): ____

4. This authorization shall be in force and effect until nine (9) months after my death. **OR** ___________________________________, (*insert date or event*) at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Full name of Patient: _________________________________ Date of Birth: ___________________

______________________________ [*signature of patient*] Date: _________________________

If applicable, legal representatives sign below:

Name of legal representative: _____________________________________

Signature of legal representative: __________________________________ Date: _______________