HIPAA RELEASE OF MEDICAL INFORMATION AUTHORIZATION

1. I, _____[print name], hereby authorize Mt. Lemmon Fire District and its affiliates, employees and agent [collectively, "Mount Lemmon 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. To revoke this Authorization, I understand that I must do so by written request to Mt. Lemmon Fire District's Privacy Officer at:

PO Box 759
Mt. Lemmon, AZ 85619

chief@mlfdaz.org

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.

8. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.

9. I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Full name of Patient: _____ Date of Birth: _____

_____ Date: _____
[signature of patient]

If applicable, legal representatives sign below:

Name of legal representative: _____

Relationship to Patient (parent, legal guardian, etc.):

_____

Description of the authority of personal representative:

Signature of legal representative: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____