AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date(s) of Service: _____

I, the undersigned, _____, authorize the Village of Fayetteville,
[Print name of patient or authorized representative]
including its Fire and Ambulance Departments, to release the health-related information of the patient named above to:

_____
[Name & address of person or organization to which disclosure is made]

This Authorization covers the following health-related information:
Medical Records including Pre Hospital Care Reports: _____
Other: _____
_____
_____

This Authorization also includes authority to copy any and all such records.

The purpose for this Authorization is:

_____

This Authorization expires on: _____ or the occurrence of the following event:

_____

I understand that I may refuse to sign this Authorization. Treatment, payment, or enrollment in a health plan or eligibility for benefits will not be conditioned on signing this Authorization. I may revoke this Authorization at any time in writing. Such revocation will not affect any use or disclosure already taken in reliance upon this Authorization. I understand that once health information is disclosed pursuant to this Authorization, it is subject to redisclosure and may no longer be protected by privacy laws.

_____ _____
Signature of Patient Date

or

_____ _____
Signature of Patient Date

Authorized Representative

_____
Basis of Legal Authority if Signed by Authorized Representative