AUTHORITY TO RELEASE MEDICAL AND/OR HOSPITAL RECORDS IN ACCORDANCE WITH HIPAA

To: Town of Bow Fire Department/Ambulance
Address: I 0 Grandview Road Bow, NH 03304

Patient Name and Date of Birth: ______________________________

Patient Address: ______________________________

Date of Service: ______________________________

Send medical records to: ______________________________

You are hereby authorized to furnish and release to ______________________ of

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his/her agents or representatives, any and all medical records pertaining as to my condition, and, if requested by them, to allow them, or any physician appointed by them, to examine and make copies of all medical records and hospital records, x-ray reports, doctor's studies, physical therapy records and nurses' notes, in your possession concerning any condition or treatment and the expenses incurred for medical service rendered.

The information which may be disclosed to any attorney shall include, but not be limited to, all information concerning the dates, history of illness, diagnostic and therapeutic information, social service consultation, psychiatric/psychological treatment and reports, drug/alcohol abuse (42 CFR, Part2) treatment and reports, and/or any treatment or reports concerning HIV infection/AIDS disease or communicable disease.

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this communication will reveal my presence as a patient in a treatment facility and I do so voluntarily and willingly for the purpose as stated above.

I understand that I have a right to revoke this authorization at an y time. I understand that if I revoke this a authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the l aw provides my insurer with the right to contest a cl aim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164, 524. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

The foregoing authority shall continue in force for 6 months unless earlier revoked by me in writing.
A photo static copy of this authorization shall be considered as an original.

Signed: __________________________________ Date: _________
Patient, Parent or Legal Guardian for Minor, or Legal Representative.

Signed: __________________________________ Date: _________
Notary Public/Justice of the Peace.