AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

PATIENT BIRTH DATE: _____

PATIENT SOCIAL SECURITY NUMBER: XXX – XX – _____ (last 4 digits only)

PATIENT ADDRESS: _____

TO: City of Henderson Fire Department FAX: (702)267-2281
240 Water St. MSC 1012 Attn: Rose Fuscaldo
PO Box 95050
Henderson, NV 89009

I hereby authorize the City of Henderson Fire Department to disclose medical record(s) information and/or protected health information of the patient listed above to:

Attorney/Firm/Requestor Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Purpose: _____

For treatment date(s): _____

- I understand that this authorization is voluntary.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected.
- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____

Date Signature Relationship to patient

STATE OF _____)
SS.)
COUNTY OF _____)

On _____ personally appeared before me,
a Notary Public, _____
who acknowledged to me that _he executed the above instrument.

_____

Notary Public in and for said County and State