AUTHORIZATION FOR RELEASE OF INFORMATION

I, The Undersigned, Do Hereby Authorize:

Name of Facility: City of Santa Fe Fire Department
Address: 200 Murales Road
City, State, zip Santa Fe, New Mexico 87501

To Release Information from the Records for treatment or examination of:

Patient's name: _____
Patient's DOB: _____
Patients SS#: _____

Information authorized to be released:

____any and all medical records and films

____any and all information acquired during treatment or examination:

Information may only be released to requestor:

Name: _____
Address:_____
Fax: _____
And
Any other person issuing a legally valid subpoena for such Information.

NOTE: All prior authorization for access or release of any of patient records for any other information, Given to any entity, except to treating health care providers, are hereby revoked. This is Prior release revocation does not apply to a court order or subpoena.

Purpose of Disclosure: For use in legal claim.

Understanding:

1. I understand that this consent may be revoked in writing at any time. With the exception and to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above-named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days from the date of signing. To initiate revocation of this authorization, direct all correspondence to the "Specific Request" above.
2. I understand that this consent is to include [the] disclosure of [the following if initialed below]: (INITIAL ONLY IF REQUESTED TO DO SO).
   _____Alcohol and/or drug abuse records _____Psychiatric records

   _____Sexually transmitted disease information _____HIV/AIDS information
3. I understand that a photocopy of this authorization is to be considered valid as the original.
4. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

Signature: _____
(Patient or Personal/Legal Representative) (Next of kin or Legal Guardian to sign only if patient is a minor, legally incompetent or deceased)

_____ Date: _____

Relationship to patient of Personal/Legal representative Signing: _____

[This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) 45 C.F.R. 16.508©]