HIPAA Release of Information
Authorization Form

I,_______________________________________hereby authorize________________________and its affiliates, its employees and agents (collectively___________________________), to release to _________________________________ **[Insert full name of person/organization]** my personal health information maintained by the City of Thornton Fire Department (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me: __________________________________**[Describe information not to be disclosed, if any]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of__________________________________**[Insert date/event upon which this authorization expires]** or the date my coverage ends with _______________________. I understand that I have a right to revoke this authorization by providing written notice to the City of Thornton Fire Department. However, this authorization may not be revoked if the City of Thornton Fire Department, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: ____

Signature of Patient: ____

Date:____

State of Colorado
County of ____________________________

Signed before me on _______________________________, 20________

by______________________________________(name(s) of individual(s) making statement).

____
Notary's Official Signature

____
Title of Office

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Commission Expiration