HIPAA Form A Missouri 22nd
Judicial Circuit Approval
11/24/03

AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION PURSUANT TO HIPAA 45 CFR PARTS 160 AND 164
(for matters after suit filed)

MONARCH FIRE PROTECTION DISTRICT

I hereby authorize/request MONARCH FIRE PROTECTION DISTRICT to release my personal health and medical information as described below:

Patient:
Date of Birth:
Social Security Number:

This Authorization is being presented pursuant to litigation, and so please note that this Authorization includes medical records, reports and other medical documents (including records or information from other health care providers, i.e. secondary release records) in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes, but is not limited to, records of all examinations, treatments and test, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRIs and CT scans and post-mortem records, if applicable, PROVIDED THAT THE EXAMINATIONS, TREATMENTS AND/OR TESTS INVOLVE OR RELATE TO COMPLAINTS, INJURIES, ILLNESSES OR CONDITIONS PERTAINING TO THE FOLLOWING ALLEGED INJURY:

This Authorization does not include an authorization for records or health information concerning alcohol/drug abuse, HIV testing, HIV results and/or AIDS information unless specifically listed above. A separate authorization is required for the release of psychotherapy notes. See 45 C.F.R. § 164.508.

THIS AUTHORIZATION DOES NOT INCLUDE AND SPECIFICALLY PRECLUDES ANY EX PARTE INTERVIEWS OR DISCUSSIONS. IT IS ONLY AN AUTHORIZATION FOR RELEASE OF DOCUMENTS.

This Authorization shall remain in effect from six (6) months from the date signed below. Therefore, you may receive a supplemental request for documents. Provided you have an original or a copy of the authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required. A copy of this authorization is valid as long as the authorization has been completed in the presence of a notary.

Mail To:

Deputy Chief Nick Harper
13725 Olive Blvd.
Chesterfield Missouri 63017

The patient further requests that the health care provider supply copies of all documents produced pursuant to this authorization to the attorneys at the above address, at their expense.

For the purpose of litigation.

NOTE TO PATIENT OR REPRESENTATIVE: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA and its implementing privacy regulations.

I UNDERSTAND that neither MONARCH FIRE PROTECTION DISTRICT, nor any of its affiliated health care providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it.

I UNDERSTAND that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire six (6) months from the date signed if I do not cancel it in writing before that expiration time. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this Authorization.

I UNDERSTAND that I may inspect or copy the information to be used or disclosed, as provided in C.F.R. 164.524.1 understand that I have a right to a signed copy of this Authorization upon request.

I,_____, hereby state that I have read all pages of this release in its entirety and understand it and agree to it.

_____

Signature of Patient/Legal Guardian/Personal Representative/Other Date

I am signing this Authorization on behalf of

(Self/Personal Representative/Legal Guardian/Other)

If you are signing on behalf of a patient for whom you are the personal representative, you must attach a copy of the appointment order as personal representative. If you are signing as representative or the patient other than as personal representative, state the basis of your authority to request the records of the patient.

STATE OF MISSOURI)

)

COUNTY OF _____)

Subscribed and sworn to before me this _____day of _____ 2013

_____

Notary Public

My Commission Expires:

_____

* *

Facility Use Only: *Date Access/Request Granted:* _____

*Other Disposition (Date/Action):*_____