

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date(s) of Service: _____

I, the undersigned, _____, authorize the Village of Fayetteville,
(Print name of patient or authorized representative)
including its Fire and Ambulance Departments, to release the health-related information of the patient
named above to:

(Name & address of person or organization to which disclosure is made)

This Authorization covers the following health-related information:

Medical Records including Pre Hospital Care Reports: _____

Other: _____

This Authorization also includes authority to copy any and all such records.

The purpose for this Authorization is: _____

This Authorization expires on: _____ or the occurrence of the following event: _____

I understand that I may refuse to sign this Authorization. Treatment, payment, or enrollment in a health plan or eligibility for benefits will not be conditioned on signing this Authorization. I may revoke this Authorization at any time in writing. Such revocation will not affect any use or disclosure already taken in reliance upon this Authorization. I understand that once health information is disclosed pursuant to this Authorization, it is subject to redisclosure and may no longer be protected by privacy laws.

Signature of Patient

Date

or

Signature of Patient

Date

Authorized Representative

Basis of Legal Authority if Signed by Authorized Representative