AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION of I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes an hese types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information he person(s) indicated in Item 8. 2. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 3. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibit or benefits will not be conditioned upon my authorization of this disclosure. 4. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no onger be protected by federal or state law. 5. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICA	Patient Name	Date of Birth	
n accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I inderstand that: This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL IEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION. It place my initials on the appropriate line in Item 9(a). In the event the health information described below includes an nese types of information, and I initial the line on the box in Item 9(a). I specifically authorize release of such information has express of; indicated in Item 8. I have the right to revoke this authorization at any time by writing to the health care provider Itsets below. I anderstand that I may revoke this authorization except to the extent that action has already been taken based on this uthorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility or benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may nonger be protected by federal or state law. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICA ARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b) 7. Name and address of health provider or entity to release this information: Morgan County Ambulance Service, 1000 E Railroad, Fort Morgan, CO 80701 8. Name and address of person(s) or category of person to whom this information will be sent: 9(a). Specific information to be released: Medical Record form (insert date)	Patient Address		
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Signature of Patient or representative authorized by law.