AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Address: _____

Birth Date: _____ Social Security #: _____

TO: _____

Address: _____

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical records to The City of Allentown.

I authorize The City to disclose and/or release such information to necessary third parties, including the International Association of Fire Fighters, Local 302, to process Heart and Lung and Workers' Compensation Claims.

I hereby authorize the release of a true and complete record of all medical, dental, and surgical services and hospital treatment, including x-rays, MRI and CT scan studies, laboratory tests, and all other medical and surgical data, as well as any and all bills in support of said services, which are in your possession or under your control relative to my course of treatment, and allow the bearer to examine said records and reports.

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contract the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference, I also understand that this consent will expire two (2) years after the date of signature or automatically when the records requested on this authorization have been released. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). You are directed a photostatic copy of this Authorization is to be accepted with the same force and authority as the original.

Date: _____ Patient Signature: _____