



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of patient) (Name of person or facility which has information)

release the following health information: _____

To:

(Name and title or facility name to receive health information)

(Street address, city, state, ZIP code)

(Telephone number)

(Fax number)

For the following purposes: _____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal/Agency Representative:	Date
On Behalf of _____ Name of Patient	

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV
IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD,
MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

Return this form and any attachments to:

Custodian of Records
North Tahoe Fire Protection District
P.O. Box 5879
Tahoe City, CA 96145
Fax: 530.583.6909
Email: mcelravey@ntfire.net

PERSONAL/AGENCY REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE

- | | |
|--|---|
| <input type="checkbox"/> PARENT | <input type="checkbox"/> CONSERVATOR |
| <input type="checkbox"/> GUARDIAN | <input type="checkbox"/> EXECUTOR OF WILL |
| <input type="checkbox"/> MEDICAL POWER OF ATTORNEY | <input type="checkbox"/> OTHER |

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU
ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL,
OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing
paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)