AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE:

- Federal law says that the Wauconda Fire District cannot share your Health Information without your permission. If you sign this form, you are giving Wauconda Fire District permission to share your Health Information that Wauconda Fire District has with the person/entity you indicate below.
- This Authorization is voluntary.

PURSUANT TO 735 ILCS5/8-2001, 735 ILCS 5/8-2003 OF THE ILLINOIS COMPILED STATUTES AND HIPAA, I HEREBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

My name: (print).....

Date of birth: .....

Date of service: .....
I give permission to: **Wauconda Fire District** to share my Health Information with:

.....
so that this person or entity may assist me with my health care issues.

This form must be signed by EITHER the Recipient OR by the Personal Representative. The Recipient's parent may sign for the Recipient if the Recipient is a minor.
Patient /Recipient Signature: .....

Date: .....

If this form is signed by the Personal Representative, please include a copy of the document naming the Personal Representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.
Signature of Personal Representative: .....

Date: .....

Relationship of Personal Representative:

.....