Patient Authorization For release of Protected Health Information

To Permit Use and Disclosure of Health Information By The Monarch Fire Protection District

Re:		/
Patient Name	Social Security Number	Date of Birth
I am either the patient named above or t	the patient's legally authorized representative.	
By signing this form, I authorize the Mo	onarch Fire Protection District to use or disclo	se to
Person or class of persons to whom use or disc	closure would be made	
the following protected health informati	ion: Identify the information in a specific o	and meaningful fashion
The purpose of the use or disclosure is:	Describe each purpose of the requested use	or disclosure
authorization, I must do so in writing.	ons, I have the right to revoke this Authoriza The procedure for how I may revoke this Autl onarch Fire Protection District's Notice of Pr	norization, as well as the exceptions to my
	this Authorization. I also understand that the ayment, enrollment in a health plan, or elig	
	disclosed pursuant to this Authorization, it is could be redisclosed by the person or agency	
This authorization expires automatically	y upon	the patient or the purpose of the use or disclosure.

I have read and understand the information in this authorization form.

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Signature of Patient:		
Please print name:	Date:	
-	— OR —	
Authorized Representative:		
Please print name:	Date:	
Please explain Representative's authority to act on behalf of the Period in		
If Representative's authority to act on behalf of the Patient is of such written document to this Authorization.	based on a written document, please attach a copy	
State of Missouri) SS County of St Louis)		
On this day of, 201, before me personally appeared, to me known to be the person described in and who signed this Patient Authorization, by reviewing his/her driver's license and witnessing his/her execution hereof, and who acknowledged that he/she signed it voluntarily as his/her free act and deed, with full authority to obtain the requested information under federal and state law.		
IN TESTIMONY WHEREOF, I have hereunto set my State aforesaid, the day and year above written.		
My Commission Expires:	Notary Public	