AUTHORIZATION TO RELEASE MEDICAL INFORMATION
made pursuant to HIPAA, the Privacy Rule, 45 C.F.R. §164.508

NAME OF UNDERSIGNED INDIVIDUAL, WHOSE HEALTH INFORMATION IS TO BE DISCLOSED:
SOCIAL SECURITY NUMBER: ____-____-_____
DATE OF BIRTH: ___ /___ /___ (mm/dd/yyyy)

(1) DESCRIPTION OF INFORMATION TO BE DISCLOSED: **All health information regarding the undersigned individual, including, but not limited to: medical information included in any 911 calls, police traffic radio, and CAD reports regarding an emergency and related 911 call on _____.**

(2) NAME OR OTHER SPECIFIC IDENTIFICATION OF T HE PERSON(S), OR CLASS OF PERSONS, AUTHORIZED TO MAKE THE REQUESTED DISCLOSURE: **The undersigned individual, hereby authorizes Forsyth County (hereinafter the "Covered Entity") to disclose any and all health information regarding the undersigned, including the records described in paragraph 1 of this Authorization.**

(3) NAME OR OTHER SPECIFIC IDENTIFICATION OF THE PERSON(S), OR CLASS OF PERSONS, TO WHOM THE COVERED ENTITY MAY MAKE THE REQUESTED DISCLOSURE: **To the undersigned individual.**

(4) DESCRIPTION OF PURPOSE OF THE REQUESTED DISCLOSURE: **At the request of the undersigned individual.**

(5) EXPIRATION DATE OR EXPIRATION EVENT THAT RELATES TO THE INDIVIDUAL OR THE PURPOSE OF THE DISCLOSURE: **This Authorization will remain in effect for one (1) month following the execution of this Authorization.**

(6) STATEMENT OF THE UNDERSIGNED INDIVIDUAL'S RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING; THE EXCEPTIONS TO THE RIGHT TO REVOKE; AND A DESCRIPTION OF HOW THE INDIVIDUAL MAY REVOKE THIS AUTHORIZATION: **The undersigned individual understands that he/she has the right to revoke this Authorization in writing at any time. Any revocation of this Authorization must be in writing and presented to the covered entities who have received this Authorization. The undersigned individual understands that such revocation will not apply to health information that has already been released in response to this Authorization.**

(7) STATEMENT THAT THE COVERED ENTITY MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS ON THE SIGNATURE OF THIS AUTHORIZATION BY THE UNDERSIGNED INDIVIDUAL. **The undersigned individual understands that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the undersigned individual signs this Authorization, except under certain circumstances which are not applicable to the undersigned individual.**

(8) STATEMENT THAT THE HEALTH INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY THE RULE: **The undersigned individual understands that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by this rule.**

(9) WAIVER OF PRIVILEGES: **The undersigned individual hereby waives any psychiatrist-patient and psychologist-patient privileges and any other privileges that exist with respect to the records requested by this Authorization. This waiver of privileges is not intended to create, and should not be construed as creating, any compound authorization.**

(10) DISCUSSION OF MY HEALTH INFORMATION: **The undersigned individual hereby gives permission for any health care provider described in paragraph 2 of this Authorization to discuss his/her health information, medical care and treatment with the undersigned individual.**

(11) PHOTOSTATIC COPY OF SAME AS ORIGINAL: **A photostatic copy of this signed Authorization shall be accepted and treated as having the same force and effect as an original.**

(12) HIPAA RULE OF PRIVACY: **The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A major goal of the privacy rule was to assure that an individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.**

(13) COMPLIANCE WITH HIPAA: **This Authorization complies with HIPAA Privacy Rule as outlined at 45 C. F. R. § 164.508.**

_____ _____

Date Signature of the Individual, or
Personal Representative of the Individual*

* If the Authorization is signed by a Personal Representative of the Individual, a description of such representative's authority to act for the individual: _____.