

**MONROE TWP. FIRE & AMBULANCE PROTECTION DISTRICT
(MTF&APD)**

NOTICE OF DISCLOSURE, RELEASE OF MEDICAL INFORMATION,
NOTICE OF DISTRICT PROTECTED HEALTH INFORMATION (PHI) PRIVACY POLICY

Pursuant to applicable State and Federal laws and regulations protecting my right to confidentiality of medical information concerning me and subject to the notice of my rights as delineated on the reverse side of this document, I hereby acknowledge receipt of MTF&APD Privacy Policy and Notice of Disclosure of Protected Health Information (PHI) about me or my minor child or legal ward, and furthermore I authorize the MTF&APD to release to its billing agents, any of my medical insurance companies, Medicare, Medicaid, or Supplemental Medicare insurance, any and all medical information about me, my minor child or legal ward, hereinafter referred to as Protected Health Information (PHI) needed to determine insurance benefits payable on my behalf for the service currently provided. I specifically consent to release of information or medical records pertaining to diagnosis, prognosis, and treatment for physical and/or mental or emotional illness, including but not limited to alcohol, drug abuse, or HIV. This release is effective until written notice is received by MTF&APD via certified mail notifying MTF&APD that this consent to release medical information is withdrawn.

I understand that if I am not covered by Medicare, Medicaid, or any other type of medical insurance, or should any third party payor deny payment of said claim for any reason whatsoever, I am fully and personally responsible for prompt payment for all charges for the services rendered by MTF&APD. I further agree that if said charges are not paid and it is necessary for MTF&APD or its agent to bring suit to collect all or part of said charges, in addition thereto I am responsible for and will pay all costs for such suit, including reasonable attorney fees.

I permit a copy of this release to be used in place of the original for the purpose of billing Medicare, Medicaid, and/or any other insurance carrier, for the request of payment of medical insurance benefits to MTF&APD for services rendered to my care. Medicare, Medicaid, Supplemental Medicare insurance, and/or any other insurance carrier may forward benefit payments directly to MTF&APD.

I hereby acknowledge that I have read and fully understand this Notice and Release as well as the Notice of my privacy rights on the reverse side of this document by me signed.

(Give this portion to patient)

(tear here)

(This portion stays with EMS report)

(tear here)

HIPAA Signoff

Patient Name: _____ Date of Incident: _____

Address: _____ Social Security No.: _____

City: _____ State: _____ Zip Code: _____

Signature of Patient or Responsible Party Date: _____

Patient, if 13 years or over, is also required to sign release

Witness: _____