

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____

Address: _____

Telephone Phone: _____

Date of Birth: _____

Purpose. The purpose of this authorization is to ensure City of Olathe does not obtain, use, or disclose legally protected health or medical information about you, without your permission, or, for purposes other than those permitted by law.

Types of information for which your permission is requested. We request your permission to obtain, use, and disclose the following types of information about you, for the limited purposes identified herein: Medical information relating to your special needs to assist in your safe evacuation or to render assistant to you in the case of a bona fide declared emergency.

Purpose for Disclosure. The information gathered will be used solely by Emergency Management Personnel to assist in the safe evacuation of or render assistant to the person identified herein in the case of an emergency.

Persons authorized to make disclosures. Only the following persons are authorized to make the uses and disclosures identified herein, for the purposes described herein: your family doctor, yourself or your legal guardian and Emergency Management personnel in the event of a bona fide declared emergency.

Persons to whom the disclosures may be made. The disclosures authorized and made pursuant to this authorization will only be made to the following persons for the purposes described herein. Disclosure of information shall only be made to Law Enforcement and Emergency Management personnel in the event of a bona fide declared emergency.

Expiration and Revocation. This authorization shall not expire and shall remain open and in effect until you or your legal guardian revoke same in writing.

You may revoke this authorization at any time by notifying Emergency Management in writing at 1225 S. Hamilton Circle, Olathe, KS 66061.

I understand that any actions taken in reliance on this authorization prior to its revocation cannot be reversed.

Re-disclosure. The information obtained through this authorization is subject to re-disclosure by the recipient of the information. However, if any information is re-disclosed, the protections provided herein will continue to be applicable, and the information will not be reused or disclosed, except as authorized by you, or as permitted by law.

I have read and understand the information contained herein, and by my signature below, authorize the receipt, use and disclosure of the information described herein, for the limited purposes described herein. No inducement has been made to compel my signature hereon.

Signature

Date

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to individual authorizing release of medical information, or nature of authority (*health care power of attorney, guardian, other statutory authorization, etc.*):

Address: _____

Contact phone number: _____

Signature of Personal Representative

Date

A COPY OF THE SIGNED AUTHORIZATION MUST BE GIVEN TO THE INDIVIDUAL GIVING THE AUTHORIZATION.