AUTHORIZATION TO RELEASE EMERGENCY RESPONSE RECORDS

TO the PROVIDER: _____
_____
_____

You are hereby requested to permit any representative of the firm of _____ (hereafter the "Bearer") to inspect and make copies of all fire/rescue, ambulance and other confidential medical records that are in your possession concerning my physical or blood condition and mental health records if checked. This authorization also allows rescue, emergency and/or medical personnel who were at the scene of the Incident or involved in transporting the patient to the hospital to speak with the Bearer, but does not require them to do so.

Please provide the requested information for all dates of treatment and/or hospitalization with you. The information to be disclosed is:

- ☒ Admission reports
- ☒ History & Physical exams
- ☒ Laboratory tests & diagnostic reports or studies
- ☒ Discharge summaries
- ☒ X-ray reports
- ☒ Social history
- ☒ Nurses' Notes
- ☒ Progress reports
- ☒ Correspondence
- ☐ Death Certificate
- ☒ Outpatient records
- ☒ Consultation reports
- ☒ Pathology reports
- ☒ Nurses and doctors notes
- ☒ X-rays
- ☐ HIV or AIDS records/status
- ☐ Other
- ☒ Billing statements and X-ray film
- ☒ Ambulance and emergency rescue reports
- ☐ MMPI and Mental Health records

This information is to be supplied because I have commenced a civil action regarding an allegedly defective vehicle and the defendants seek these records as part of their defense. I understand that any re-disclosure of these records is protected by the Confidentiality Order entered in *In re Yamaha Motor Company Rhino Products Liability Litigation, MDL 2016.*.

Treatment, payment, enrollment or eligibility of benefits cannot be conditioned on obtaining the individual's authorization.

I understand that I may revoke this consent at any time in writing and that upon fulfillment of the above-stated purpose(s), this consent will automatically expire without my express revocation. This authorization shall remain effective for **six months** from the date hereof. A photocopy of this authorization will be treated in the same manner as the original.

This authorization complies with the requirements of the Federal HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, effective April 14, 2003.

Date: _____

Patient's Social Security No._____

Patient's Date of Birth: _____

_____
Signature:

_____
Patient's Name

_____
(Address)

_____
City State Zip