CITY OF PRIEST RIVER

P.O. Box 415; 552 High Blvd.
Priest River, Idaho 83856
(208) 448-2123

CITY OF PRIEST RIVER 2024-2025
MEDICAL INFORMATION RELEASE AND DOCTOR'S STATEMENT FORM

(For use in requesting City assistance in the removal of snow berms from driveways)

IMPORTANT: <u>All members of the household</u> must complete and have their physician(s) sign a copy of this form. The completed <u>forms must be returned on or before November 15, 2024</u>.

Patient's Printed Name: _____

Patient's Address: _____

Telephone: _____ E-mail: _____

I hereby authorize my doctor to release to the City of Priest River information regarding my medical condition which relates to my ability to shovel snow.

I have read and understand the following:

- I may revoke this authorization at any time prior to its expiration date or event by notifying the providing person/organization in writing, but revocation will not have any effect on any actions the entity took before it received the revocation.
- Only the following may be conditioned upon this Authorization being provided:
    1. Research - related treatment
    2. Enrollment in the health plan or eligibility for benefits when relating to underwriting or risk rating determinations and the request is not for psychotherapy notes
    3. Health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- Disclosure of this information by an entity subject to HIPAA privacy regulations to a person/entity may be subject to re-disclosure by the recipient without my further authorization.
- **This authorization will expire at the end of the 2024-2025 snow season.**

PATIENT SIGNATURE: _____ **DATE:** _____

As Primary Physician for_____, I affirm that the patient has a medical condition/disability that prohibits his/her ability to remove heavy snows created by a plowed berm.

_____ **Physician:** Please initial here if the patient has a medical condition/disability that is permanent in nature and you recommend indefinite snow berm removal assistance.

Physician's Printed Name: _____

Physician's Signature: _____

Physician's Address: _____

Fax to: 208-448-2232, Attention Department of Public Works