

CONSENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I am applicant for employment with the Cañon City Area Fire Protection District (District) and hereby consent and authorize you to release any information related to my employment as may be requested by the authorized agents and/or representatives of the District. This Consent and Authorization shall specifically include but is not limited to, my employment history, details of my job description, hours worked, compensation, time off work as a result of injuries or illness, any information of a confidential or privileged nature, on-the-job injuries or illness and other worker's compensation information.

This Consent and Authorization shall also specifically include any mental health and medical information maintained in connection with my employment as well as any drug and alcohol testing results and related records, including any protected by Federal law 42 CFR Part 2, 45 CFR and HIPAA. I understand that the District may NOT disclose it to someone else without my permission, unless permitted by law. I may cancel this authorization before it expires by writing a letter stating that I want to cancel it. I must sign the letter, date it and have it notarized or witnessed. The letter must be received by the District. I understand that the letter will not have any effect on the uses/disclosures of any information that are made before the District receives my letter.

I hereby release and hold harmless the Cañon City Area Fire Protection District, with which I am seeking employment, together with any entity, organization, company or person furnishing information pursuant to this Consent and Authorization, from any claims or liability that may arise or result from the transfer of information authorized pursuant to this document.

Photocopies of this authorization shall be deemed as valid as the original. This Consent and Authorization for Release of Employment Information shall be valid until December 31, 2010.

Print Full Name: _____

Current Address: _____

Social Security Number _____/_____/_____

Date: _____

Signature: _____