CITY OF Grand Junction COLORADO
FIRE

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

Receiving Facility Transfer of Responsibility

GJFD Call #_____
Date:_____

Billing Authorization and Responsibility for Payment

I understand that I am financially responsible for the services provided to me by the Grand Junction Fire Department regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the City of Grand Junction or its billing agent for any services provided to me by the Grand Junction Fire Department.

I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services (formally the Health Care Financing Administration) and its carriers and agents, as well as to the City of Grand Junction and its billing agents, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by the Grand Junction Fire Department, now or in the future.

I agree to immediately remit to the City of Grand Junction any payments that I receive directly from any source for the services provided to me. A copy of this form is as valid as the original. I acknowledge that I have been provided with a copy of the City of Grand Junction Fire Department's **Notice of Privacy Practices (see attached)** on this date.

Complete 1, 2 **OR** 3 for _____:
Patient Name *(Please Print)*

(1) *Patient Signature*: _____, **OR**

(2) _____ _____
Patient Representative's Signature *Relationship to Patient*

Patient unable to sign because: _____, **OR**

(3) Patient unable to sign because: _____

_____ _____ _____
GJFD Employee Signature *FD #* *Station #*

Receiving Facility Signature:
Transfer of responsibility for _____ has been made
Patient's Name

to me on this date:_____.
Date

_____
Receiving Facility Signature