State of Illinois)
) SS
County of _____)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ (hereinafter referred to as the "Undersigned"), hereby provides the following consent:

1. That the Board of Trustees of the Des Plaines Firefighters' Pension Fund and/or its attorneys, Puchalski Goodloe Marzullo, LLP, be permitted to examine and obtain copies of any and all of the Undersigned's records, including but not limited to, the following: hospitals, doctors, psychiatrists, psychologists and medical records from any medical provider of every sort and kind; records of interviews with doctors, psychiatrists, psychologists; records of examinations, diagnosis, care treatment and opinions, city personnel files and other employment files and workmen's compensation files.

2. That said disclosure be made to the above-referenced Pension Board and/or its attorney are pursuant to the Undersigned's application for disability pension benefits filed with the Pension Board.

3. That the Undersigned fully acknowledges that said disclosure of the records herein are necessary in order to provide the Pension Board with adequate knowledge of the Undersigned's medical history as the same may relate to his or her application for disability pension benefits.

4. The Undersigned acknowledges that his or her refusal to consent to the disclosure of his or her medical records as provided herein may be deemed by the Pension Board to constitute a failure of cooperation by the Undersigned and may further result in the Pension Board being inadequately informed respecting the Undersigned's medical history and therefore unable to render a proper determination concerning the Applicant's application for disability pension benefits.

5. **The Undersigned acknowledges that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.**

With respect to medical records or documentation pertaining to psychological or mental injuries or illnesses, alcohol/substance abuse, or human immunodeficiency virus (HIV) and or AIDS, the following paragraphs shall pertain:

A. That the Undersigned specifically consents to release of the aforementioned records

B. That this Consent and Medical Authorization shall continue in full force and effect through and inclusive of _____**, 20**____.

C. That the Undersigned retains the right to revoke this consent at any time upon written notification provided to the attention of the Pension Board and its attorney, return receipt required. That neither the Pension Board nor its attorney shall assume any responsibility concerning any revocation of this authorization or any disclosures made hereunder until each has been personally served with said statement of revocation from the undersigned.

I am willing that a Photostat of this authorization be accepted with the same authority as the original.

Dated this _____ day of _____, 20_____.

_____
Signature

_____ _____
Print Name Date of Birth

_____ _____
Address Social Security Number

_____
City/State/Zip Code

*The Undersigned acknowledges that the Illinois Mental Health Confidentiality Act (740 ILCS 110/1, et seq.), provides for certain limitations respecting the duration of the Consent (A above), and provides the undersigned with the authority to revoke said consent at any time (B above). The Undersigned acknowledges that the constraints herein, imposed by the Illinois Health Confidentiality Act, shall be limited solely to the disclosure of those documents defined under said statute (740 ILCS 110/1, et seq.). These limitations shall have no application to the disclosure of any medical records or other documentations that fall outside the scope of said statute or other restrictive laws.