



Public Works Department  
Maintenance Divisions

It is that time of year again to prepare for the snow season. As you know, each year we compile a list of disabled citizens in the City of Post Falls who are unable to clear the berm that is left in front of their driveway when snowplowing is done.

Enclosed is a City of Post Falls Medical Information Release and Doctor's Statement Form. **In order for a household to qualify for the *City of Post Falls Disabled Snowberm Removal Program*, all members of the household must submit the enclosed form.** If you need additional forms for other disabled members of your household, please call. If you need help with your snowberm, you must have this form filled out by you and your primary care physician and returned to the Public Works Maintenance Division. This Medical Information Release and Doctor's Statement Form will expire at the end of the snow season.

The Medical Information Release and Doctor's Statement Form can be sent to us by you or your physician in the following manner:

1. Mail to: P.W. Maintenance Division, Attn: Kathy, 800 N. Public Works Way, Post Falls, Idaho 83854, or
2. Fax to: 208-777-2840, Attention: Kathy

Please return your completed Medical Information Release and Doctor's Statement Forms to the P.W. Maintenance Division by November 1, 2011. We will install a curbside marker so that our snowplow operators can quickly identify those homes that are on our list for snowberm removal.

Please understand that this courtesy can only be provided after streets are cleared for the motoring public. We ask for your patience during snowplow operations. The berms are normally removed during the last part of snow removal operations for your street, time permitting. Should you have an emergency and need to get out immediately, please call the P.W. Maintenance Division at 773-1722 and we will attempt to assist you.

If you have any questions, please feel free to call me at 773-1722 Monday-Friday from 7:00 a.m. to 3:30 p.m.

Sincerely,

Kathy  
Department Specialist  
P.W. Maintenance Division



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Maintenance Divisions

**CITY OF POST FALLS DISABLED SNOWBERM REMOVAL PROGRAM  
MEDICAL INFORMATION RELEASE AND DOCTOR'S STATEMENT FORM**

**PATIENT'S PRINTED NAME:** \_\_\_\_\_

**PATIENT'S ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

**This authorization will expire at the end of the snow season.**

I have read and understood 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.

**Dated:** \_\_\_\_\_

**Patient Signature**

**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'S PRINTED NAME:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_

**PHYSICIAN'S ADDRESS:** \_\_\_\_\_