RELEASE
FOR **BELIEVE 271**

I, _____, the undersigned applicant, understand that the information I have provided to Believe 271 as part of the attached application will be disclosed to others as part of Believe 271's internal selection of awardees.

The following specific person/class of person/facility is authorized to use or disclose information about me:

- Believe 271, its agents, officers, directors; and
- Committee Members involved in selection of awardees*

  * Committee Members may include individuals from Barneveld Volunteer Fire Department, other Volunteer Fire Departments or Auxiliaries acting to assist Believe 271 in its selection of awardees.

The specific information that may be disclosed includes:

Information provided on the Believe 271 Application Form and any and all supplemental materials supplied, which information may include:

- Identifying Information (including Name, address, date of birth, social security number)
- Family Information
- Employment Information
- Medical Diagnosis and treatment information
- Financial Support

I also understand and agree that if I am selected to receive an award from Believe 271, that my name may be disclosed and used by Believe 271 to show that donations are being allocated and also as part of its fundraising efforts to raise more donations to assist others and to carry out the mission of Believe 271.

I understand that I may revoke this authorization, at any time, by notifying Believe 271 in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that if I accept an award, that I may not revoke my authorization allowing Believe 271 to identify me by name as a recipient of such award.

I hereby authorize such uses and/ or disclosures as outlined above.

_____ _____

Signature of applicant or personal representative Date

_____ _____

Printed name of patient or personal representative and his or her relationship to patient

_____ _____

Signature of Witness (must be over 18 years old) Printed name of Witness

_____

Date