AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

I, _____, authorize the Summit Fire Protection District (District)

Patient or Patient's Representative

to release the following records, including any Protected Health Information regarding the patient that the records contain:

_____

_____

_____

_____

Please list the records you are authorizing for release with as much specificity as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons or locations. Please attach additional pages if more space is needed. **You must specifically authorize the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

The records listed above may be released to the following individual(s) or organization(s):

Name of Recipient: _____ Organization: _____

Address: _____

For the purpose of: _____

_____

OPTIONAL Authorization to Transmit via Electronic Means:

I request that the records listed above be released to the recipient by fax or email, and not by U.S. mail or delivery service. I understand the records will be sent through **unencrypted fax/email that is not secure** and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. The District is not responsible for unauthorized access of the Protected Health Information resulting from the faxed or emailed transmission, or for safeguarding the Protected Health Information upon delivery.

☐ By fax to the following fax number: _____

☐ By encrypted email to the following email address:

Expiration. Unless earlier revoked, this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.

Revocation. I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.

Patient Rights. I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

Re-disclosure. I understand that any disclosure of Protected Health Information carries with it the potential for unauthorized re-disclosure, and may no longer be protected by federal confidentiality rules.

SIGNATURE: I understand that authorization for the disclosure of these records and Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. Photocopies of this authorization may be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____ Date: _____

Description of Personal Representative's Authority: _____