HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize the Crestwood Fire Department to disclose the following health information: (check one)

___ All of my health information

___ My health information covering the period from _____(date) to _____(date)

The Crestwood Fire Department may disclose this health information to the following recipient:

Name, title or organization: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

This authorization begins on: _____ **and ends**: _____

The purpose of this use or disclosure: _____

If the patient is a minor or unable to sign, please complete the following:

___ Patient is a minor ____ years of age

___ Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Print Name: _____ **Date:** _____

Authority Type: (choose one):

___ Parent ___ Legal Guardian ___ Court Order ___ Other: _____

Additional Consent for Certain Conditions:

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.**

___ I consent to have the above information released

___ I do not consent to have the above information released

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.**

___ I consent to have the above information released

___ I do not consent to have the above information released

Your Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date**: _____