AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Southeast Weld Fire Protection District)

1. **Authorizer.** Name: _____

   Birth Date: _____

2. **Recipient.** I hereby authorize the release of my Personal Health Information (PHI) to the following Recipients(s):

   a. Name: _____
   b. Address: _____
   c. Phone Number: _____

   d. Name: _____
   e. Address: _____
   f. Phone Number: _____

3. **Circumstances.** The release of my PHI shall only be permitted under the following circumstances (check one):

   For the following limited treatment dates, events, procedure or conditions:

   _____

   For the disclosure of my entire medical record or complete patient file as it relates to all admissions, care, or medical treatment I may receive.

4. **Specific PHI Disclosures.** This authorization may include disclosure of PHI relating to alcohol or drug abuse, mental health treatment, except psychotherapy notes or confidential HIV related information ONLY IF I place my initials on the appropriate line(s) provided below:

   a. Alcohol/Drug Treatment _____
   b. Mental Health Treatment _____
   c. HIV/STD-Related Information _____

   If I am Authorizing the release of PHI relating to alcohol or drug treatment, HIV/STD-related information, or mental health treatment, the Recipient is prohibited from disclosing such PHI without my authorization unless permitted to do so under state or federal law.

5. **Purposes.** The purposes for which my PHI may be used include all of the following:

   Further evaluation
   Insurance/Reimbursement
   Legal
   Verify Treatment Status
   Other: _____

6. **Expiration.** This authorization shall expire on the following date or upon completion of the following event:

   _____

7. **Right to Revoke.** I understand that I have the right to revoke this Authorization in writing at any time, subject to the exception stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. I addition, I must sign my request and then mail or delivery my request to the Administrative Assistant at the Southeast Weld Fire Protection District.

8. **Exception to Right to Revoke.** I understand that my written request to revoke this Authorization will not affect the ability of Southeast Weld Fire Protection District to continue to use or disclose my PHI to the extent that it has been already acted upon in reliance on this Authorization.

9. **Potential for Redisclosure.** Your PHI that is disclosed pursuant to this Authorization will no longer be protected by the federal privacy law, known as HIPAA, and the recipient of your PHI may potentially redisclose it.

10. **Authorization is Binding.** The statements made in this Authorization are binding, controlling and I understand that they will take precedence over other contradictory statements made by the Southeast Weld Fire Protection District.

Authorization must be signed by the Authorizer or by the parent/legal guardian of a minor, or by the legal representative when the Authorizer lacks decision making capacity, of if the Authorizer is physically unable to sing but mentally understands and consents.

I understand that signing this agreement is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure and I will be provided with an executed copy of this Authorization.

Authorization Approval and Receipt of Acknowledgement. I hereby authorize the use or disclosure of my PHI described in this Authorization. I understand that if anyone who receives my PHI is not a healthcare provider or a health plan, my PHI may not be protected by federal privacy laws if my PHI is disclosed by that recipient.

Authorizer's or Representative's Signature: _____

Date: _____

Address: _____

Phone number: _____

If the signer is a representative of the Authorizer, please provide the following information:

Name of the Person Signing the Authorization: _____

Authority of the Representative to Sign on Behalf of the Authorizer:

_____