



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Form can be submitted via email, mail, or in-person:

Attn: Mindy Alvarez

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Patient Information

Name of Patient: _____ DOB: _____

Date of Incident #: _____ Incident #: _____ Approximate Time: _____

Location of Incident (specific address or cross streets): _____

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1. The following may receive disclosure of protected health information about me: _____
 2. The specific information will not be released unless specifically authorized by the relevant marked box(es) below:
 - ☐ Any and all fire incident reports
 - ☐ Pre Hospital Care Report
 3. PURPOSE: The purpose of the authorization is at the request of the patient/patient representative.
 4. RE-DISCLOSURE: I understand that the information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws
 5. REVOCATION: I may revoke this authorization by notifying you in writing of my desire to revoke it. However, I understand that any action or release of information requested already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions taken.
 6. PATIENTS RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45CFR 164.524. I have the right to inspect and request my medical records be amended as provided in 45CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.
 7. I understand that release of health information is voluntary.
 8. A photocopy of this document shall be deemed as valid as the original.
 9. Provide a copy of the patient's valid government-issued driver's license or passport for identity verification purposes. If the patient is a minor, provide a copy of the minor's birth certificate and a valid government-issued driver's license or identification card for the parent or legal guardian.

Print Name: _____ Date: _____

Patients Signature: _____

Telephone Number: _____

Email Address: _____

Patients Mailing Address: _____

Relationship to Patient (patient, parent, guardian, conservator, representative): _____