



Georgetown Fire Department

### Authorization to Use/Disclose Protected Health Information

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST 4 NUMBERS OF SSN: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

I hereby authorize the Georgetown Fire Department to use or disclose my protected health information (PHI). Specifically, I authorize the use or disclosure of the below selected records. Please check all that apply:

EMS (Ambulance) Medical Record  EMS Billing Records/Itemized Statement  
 Other, please specify: \_\_\_\_\_

I understand that the information in my records may include information related to sexually transmitted diseases, acquired immunodeficiency disease (AIDS), or human immunodeficiency virus (HIV). It may also include information (other than psychotherapy notes) about behavioral or mental health services or treatment for alcoholism or drug abuse. I specifically authorize the release of this information.  YES  NO Initial here \_\_\_\_\_.

Please release my records to the following: (Please provide the name, address and phone # of person/organization to which disclosure is to be made.)

Name of Person/Organization: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Date(s) of Service (DOS) to be released: \_\_\_\_\_ Must be completed.

Reason for release of records. Please check all that apply:  Medical Care  Insurance  Legal  
 Patient Request  Billing/Collections/Claims  Other, please specify: \_\_\_\_\_

This authorization is valid for \_\_\_\_\_ days from the date it is signed, unless it is revoked or a different date is provided here: \_\_\_\_\_

I understand that I may revoke this authorization at any time except to the extent that the Georgetown Fire Department has relied on the authorization. To revoke this authorization, I understand that I must do so by written request to the EMS Chief, P.O. Box 409, Georgetown, TX 78627. I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer subject to privacy protection provided by law. GFD may not condition treatment, payment, enrollment or eligibility for benefits on my agreement or refusal to sign this authorization.

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If patient has a legal representative, complete the following:

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Representative's Phone Number & Address: \_\_\_\_\_

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative. Proof of legal authority is required for legal representative and HIPPA release is required for PHI.

In order to obtain PHI, the following documentation must be provided to Georgetown Fire Department prior to PHI release:

For obtaining your own PHI, a valid state-issued ID.

For obtaining another person's PHI, a valid state-issued ID, proof of legal authority (health care Power of Attorney) and PHI release.

For obtaining a minor's PHI, a valid state-issued ID and a Birth Certificate.

For obtaining a deceased person's PHI, a valid state-issued ID, Death Certificate, and proof of legal authority to act on behalf of the decedent or the estate (not restricted to persons with authority to make health care decisions).

Submit Completed Forms To:  
Georgetown Fire Department  
ATTN: EMS  
P.O. Box 409  
Georgetown, TX 78627