GEORGETOWN FIRE DEPARTMENT

Authorization to Use/Disclose Protected Health Information

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I. Patient Information

PATIENT NAME: ____ **DATE OF BIRTH:** ______________________

ADDRESS: _________________________________ **CITY/STATE:** ____________________ **ZIP CODE:** ________

SSN: ________________ **TELEPHONE NUMBER:** ____________________________

Section II. Voluntary Authorization to Release Emergency Medical Services Records

I hereby voluntarily authorize the Georgetown Fire Department to use or disclose my protected health information (PHI) for medical services provided on __________________________.

DATE OF SERVICE

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

Section III. Name and Address of Person or Organization to Receive Patient's Health Information

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#: ____________________

Address: ____

Section IV. Purpose for Release and Expiration Date of Authorization

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: ___/___/____

If you fail to specify the above, this authorization will expire one year from the date it was signed.

Section V. Patient Rights

- **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:**
  Georgetown Fire Department, ATTN: Custodian of Records, 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.**
- **I agree that a photocopy of this form will have the same effect as the original.**
- **I understand that I am entitled to inspect or copy the protected health information to be used or disclosed. I understand that I have the right to refuse to sign this authorization and I am willing to sign this authorization.**
- **I agree not to claim damages or sue the City of Georgetown, or any of its employees or elected or appointed officials, for releasing the medical information as authorized by me in this document.**

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Section VI. Patient/Authorized Representative's Signature and Date

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 and completion of a HIPAA-Compliant Authorization Form are required to release the requested records to a legal representative.

Submit Completed Forms To

Georgetown Fire Department
Attn: Custodian of Records
P.O. Box 409
Georgetown, TX 78627

HIPAA laws will be obeyed & enforced regarding protected health information (PHI). The following is required to obtain your medical record:

- For obtaining your own PHI, a valid state or federally issued photo ID must be presented by the patient with a completed Authorization (above).
- For obtaining another person's PHI, a valid state or federally issued ID must be presented, along with proof of legal authority (health care Power of Attorney) with a completed Authorization (above).
- For obtaining a minor's PHI, a valid state or federally issued ID must be presented, along with the minor's Birth Certificate and a completed Authorization (above).
- For obtaining a deceased person's PHI, a valid state or federally issued ID must be presented, Death Certificate, and a Letter Testamentary, Letter of Administration, or other document establishing the requester as the Personal Representative must be presented.