

**ROBERTS PARK FIRE PROTECTION DISTRICT
HIPAA AUTHORIZATION FORM**

Patient's Full Name

Patient's Social Security Number

Address

Patient's Date of Birth

City, State, Zip Code

I hereby authorize **THE ROBERTS PARK FIRE PROTECTION DISTRICT** to use, disclose and/or release the above-named individual's protected health information as described below to the following:

1. The following person (or class of persons) may receive disclosure of protected health information about me:

Name

Address

City, State Zip Code

2. Please provide complete Emergency Medical Services (EMS) records from _____ to _____
3. Please provide Ambulance bill from _____ to _____
4. Other _____

In accordance with Federal Regulations, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this Authorization by notifying THE ROBERTS PARK FIRE PROTECTION DISTRICT in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. I understand that the revocation will not apply to information that has already been released in response to this Authorization. If not revoked, this Authorization expires two (2) years from date signed.
6. My purpose/use of the information is for _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient EMS records. The ROBERTS PARK FIRE PROTECTION DISTRICT charges \$25.00 for a complete copy of EMS records. Pre-payment is required.

Signature of Patient or Personal/Legal Representative of Patient's Estate

Date

Description of Authority to Act for the Patient

Witness

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

Date Received

Processed By

Run #