Cinnaminson Fire Department

Emergency Medical Services

An ISO "Class 2" Fire Department

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

(Print: First, Middle, Last)

Address:_____ Phone Number:_____

(Number, Street, City, State, Zip Code)

Reason for Request to release Protected Health Information:

☐ **My Request** ☐ **Continuity of Care** ☐ **Legal** ☐ **Other (Explain Below)**

Explanation: _____

_____

Release PHI to:

Name of Person or Institution:_____

Address: _____

Phone Number: _____ Email: _____

Authorization

I hereby authorize the Cinnaminson Fire District No. 1 to disclose the health information as contained in the Electronic Patient Care Report. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and birth control and abortion (family planning). I specifically authorize the disclosure of such sensitive health information to the person or institution noted above.

I understand that my authorization will automatically expire six (6) months from the date of signature on this form. I understand that I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and submit my written revocation to the Cinnaminson Fire District No. 1. I understand that the revocation will not apply to health information that has already been disclosed in response to this authorization.

I understand that this authorization shall operate as a complete release of liability to the Cinnaminson Fire District No. 1, officers, employees, and agents, for the disclosure of the health information as described above.

I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and/or state law.

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Signing this authorization is voluntary and I understand that the Cinnaminson Fire District No. 1 may not condition treatment, payment, enrollment or eligibility for benefits on my signing or refusal to sign this authorization.

By signing below, I understand that I am authorizing the Cinnaminson Fire District No. 1 to disclose the health information as describe above.

_____ _____

Signature of Patient or Patient's Legal Representative (as applicable) **Date Time**

_____ _____

Name of Patient's Legal Representative (Print)

Relationship to Patient or Statement of Authority to act on Patient's Behalf (i.e. spouse, parent, legal guardian, person acting *in loco parentis*, etc.)

Proof of legal right to request for such information must accompany this request in the event that someone other than the Patient is requesting such information to be released.

************OFFICIAL USE ONLY************

Date Request Received: _____ Received by: _____

Medical Record Accessed by:_____

Accessed on Date:_____

Document Provided to requested by:

☐ **Email**

☐ **Certified Mail**

☐ **Fax**

☐ **Print. If do document released to: _____**