South Adams County Fire Department

6050 Syracuse St. Commerce City, CO 80022 Phone: (303) 288-0835
Fax: (303) 288-5977

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Important Notice:
The Fire District is unable to release any information protected under HIPAA without a HIPAA-compliant release. If you do not have a HIPAA complaint-release, you may use this form and submit it with any Colorado Open Records Act seeking information subject to HIPAA.

I authorize the South Adams County Fire Protection District to release the patient identifiable health information of the individual named below:

Patient Name: _____

Address: _____

Telephone: _____ **DOB:** _____

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Name: _____ **Organization:** _____

Address: _____

Name: _____ **Organization:** _____

Address: _____

For the purpose of: _____

_____

The type and amount of information to be disclosed is as follows:

- Entire medical record, from date _____ to date _____
- Ambulance trip sheet in your possession, from date _____ to date _____
- Incident report dated _____: Report No. _____
- Other: _____

Expiration: Unless earlier revoked, this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.

Right of Revocation: I have the right to revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization.

Patient Rights: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

Re-Disclosure: I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Photocopies of this release are valid and may be used in lieu of the original.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in health plan or eligibility for benefits may not be conditioned on obtaining my authorization.

_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Representative's Name (print) and Description of Authority Date

Fire Department Use Only			
Date Received:		**Received by:**	
Request processed by:		**Request returned by:**	
		Date returned:	