ADAMS COUNTY FIRE RESCUE

8055 N. Washington St., Denver, CO 80229

(303)539-6876 / Fax: (303)287-1687

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PHONE: _____ **EMAIL**: _____

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

NAME: _____ **ORGANIZATION:** _____

ADDRESS: _____

FOR THE PURPOSE OF: _____

Please check the information to be disclosed:

☐ **RUN REPORT, DATE OF INCIDENT:** _____ ☐ **BILLING RECORDS**

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 the 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 the individual's authorization.

_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Print Personal Representative's Name and Relationship Date

PLEASE DO NOT WRITE BELOW LINE – OFFICE USE ONLY – THANK YOU.

DATE OF REQUEST: _____ TIME: _____ RESPONSE DATE/TIME: _____ METHOD OF DELIVERY: _____
NUMBER OF PAGES: _____ AMOUNT PAID: _____ PREPARED BY/TITLE: _____
DENIAL OF REQUEST AND BASIS FOR DENIAL (IF APPLICABLE): _____
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