



ADAMS COUNTY FIRE RESCUE

8055 N. Washington St., Denver, CO 80229

(303)539-6828 / Fax: (303)287-1687

ems@acfpd.org

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): _____
