Authorization to Release Protected Health Information (PHI)

To be used if requesting testimony, appearance at depositions, etc. If requesting medical or billing records, please make sure to fill in the appropriate boxes below.

To:
Platte Canyon Fire Protection District
153 Delwood Dr.
P.O. Box 222
Bailey, CO 80421

Requesting Patient
Name:

Date of Birth:

SS#:

Date of Service:

Release To
Name:

Address:

Email address:

Fax #:

By signing this authorization to release protected health information ("authorization"), I request and authorize Platte Canyon Fire Protection District (PCFPD) to release the information specified below pertaining to my health, my health care or me to the organization, individual or agency designated on this authorization. This authorization is intended to include any and all information, but is not limited to, the following types of medical information about me: information regarding drug abuse (if any), sickle cell anemia (if any), sexually transmitted disease, aids, HIV (if any), alcohol abuse or alcoholism (if any) and psychological or psychiatric conditions (if any).

Purpose or need for which information is requested
The Authorization is being requested by the patient for the following purpose(s):
(Check each box that applies.)

☐ Testimony [*Identify case name, number, and date(s) of appearance(s)]:*

☐ Other *(Description required):*

Limited to dates and conditions as described below. (*If nothing is written, no limitations will apply.)*

Specific information requested
(Check each box that applies. If no boxes are checked, all records will be released)

☐ Copy of PCFPD PCR medical records related to treatment of the patient

☐ Copy of all billing records

☐ Other (description required):

AUTHORIZATION: I understand I am not required to sign this Authorization and that my healthcare will not be affected if I do not sign this Authorization. I further understand that my written authorization is not required for PCFPD to use my protected health information for treatment, payment and health care operations or as otherwise required or permitted by law. I certify that I am making this request voluntarily. I understand that I have the right to revoke this Authorization at any time except to the extent that the Authority has already acted in reliance on the Authorization. To revoke this Authorization, I understand I must do so by written request to PCFD's Administrator. I request that this Authorization expire on _____, 20___. (If no date is assigned, this Authorization will automatically expire one year after the date signed, or when revoked in writing, whichever occurs first.) I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be subject to privacy protections provided by law. I acknowledge that I have read this Authorization and that I understand and agree to its terms. A copy of this Authorization may be used with the same effectiveness as an original.

If I have requested PCFPD provide electronic copies via E-mail or facsimile, I understand that such records will be sent unencrypted and PCFPD cannot guarantee the security of those records.

Signature of Patient _____

Printed Name _____

Date _____

If a personal representative is signing on behalf of Patient, state how authorized:

Signature of Patient Representative _____

Printed Name _____

Date _____