AUTHORIZATION TO USE AND DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

By signing this Authorization, I hereby direct the use or disclosure by Mansfield Fire Department of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

_____

This information may be used or disclosed by Mansfield Fire Department and may be disclosed to:

_____

(List name or specific identification of the person(s) or class of persons to whom you may make the requested use/disclosure)

I understand that I have the right to revoke this Authorization at any time except to the extent that Mansfield Fire Department has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Mansfield Fire Department Privacy Officer, 140 East Third Street, Mansfield, Ohio 44902. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Mansfield Fire Department to use my protected health information for treatment, payment and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of the Authorization. The Authorization is being requested for the following purpose(s):

_____

The use or disclosure of the requested information will _____ / will not _____ result in direct or indirect remuneration to Mansfield Fire Department from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Name: _____Date:_____
Signature of patient or the patient's authorized representative

If signed by patient's authorized representative, describe representative's authority:

□ Patient is a minor; I am the patient's parent and natural guardian.
□ Patient is a minor; I am the patient's guardian, appointed by the _____County Juvenile Court.
□ Patient is a ward; I am the patient's guardian, appointed by the _____County Probate Court.
□ The patient is deceased; I am the patient's surviving spouse.
□ The patient is deceased; I am the executor or administrator of the patient's estate, appointed by the _____County Probate Court.
□ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
□ Other (describe) _____

This authorization expires on: _____ (date or event)
