BAINBRIDGE ISLAND FIRE DEPARTMENT

Authorization to Use or Disclose Health Information

Form 2013-365-A

Patient name: _____ Date of birth: _____

Previous name(s): _____

Authorization: You may use or disclose the following health information:

□ All health information in my medical record
□ Health information in my medical record relating to the following treatment or condition:

_____

□ Health information in my medical record for the date(s): _____

□ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health information regarding testing, diagnosis, and treatment for: (check all that apply)

□ HIV (AIDS virus)
□ Sexually transmitted diseases
□ Psychiatric disorders/mental health
□ Drug and/or alcohol use

You may disclose this health information to:

Name (or title) and organization:_____

Address/City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Reason(s) for this authorization (check all that apply):

□ At my request □ Other (specify)_____

Authorization Expiration: (This Authorization does not permit disclosure of health information more than 90 days after the date it is signed.)

□ In 90 days from the date signed
□ On (date): _____
□ When the following event occurs: _____
(no longer than 90 days from date signed)

My Rights: I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by BIFD based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. Two ways to revoke this authorization are: 1) Fill out a BIFD **Form 2013-365-C** or 2) Write a letter to BIFD. Once health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Phone #

_____

Printed name if signed on behalf of the patient Relationship to patient