Marin County Fire Department

Authorization to Obtain or Release Patient Information

HIPAA Health and Medical Information Privacy Program

I authorize the use and disclosure of my health information as described below:

Client Name (*print*):	Date of Birth:

This authorization applies to the following information [*check or describe all information you are authorizing to be released*]:

☒ Patient Records from a specific visit (enter date and location of visit) _____

☐ Other _____

I authorize the following persons (or class of persons) to make the authorized use and/or *disclosure* of my health information:

Specific Program/Agency/Office Name: **MARIN CO FIRE DEPARTMENT** Medic#:		
Address: **PO Box 518**	City/State: **Woodacre, CA**	Zip Code: **94973**
Telephone Number: **415-507-2731**	Fax Number: **415-507-2969**	Contact Name (if known): **Kellie Sullivan Custodian of Records**

I authorize the following persons (or class of persons) to *receive* my health information *[name or identify specifically]*:

Specific Program/Agency/Office Name:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

Purpose of proposed use or disclosure *[if this authorization is for a use or disclosure requested by a client, state "At the request of the client" or* "to provide medical services for client." *Also state any limitations on authorized uses or disclosures]*:

☐ At the request of the client

☒ To provide medical services for the client ☐ Other _____

REFUSAL TO SIGN: ***You may refuse to sign this authorization****. The County may not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this authorization, unless one of the following boxes is checked:*

○ *If this box is checked, the County is requesting this authorization in order to use your health information for research. If you refuse to sign this authorization, you will not be able to participate in the research study.*

○ *If this box is checked, the County is acting as a health plan and is requesting this authorization in order to make a determination concerning enrollment or eligibility for benefits. If you refuse to sign this authorization, we may refuse enrollment or benefits.*

◉ *If this box is checked, the County is creating information in order to disclose it to a third party, and the County needs this authorization in order to make the disclosure. If you refuse to sign this authorization, the County will not create the health information.*

Under no circumstances are you required to authorize the disclosure of psychotherapy notes.

EXPIRATION: This authorization shall become effective immediately and shall remain in effect until _____ , or for one year from the date of signature. *If the authorization is for research, expiration may be "at end of research study," or "none" if the purpose is to create a research database.*

REDISCLOSURE: *If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.*

REVOCATION: *You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address on this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when the County actually receives it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.*

COPY: *You are entitled to a copy of this authorization. Please ask for one.*

Client or Representative's Signature:		Date:
Name of Representative (*print*):	Authority (*Role*) ☐ Parent ☐ Guardian ☐ Personal representative ☐ Other _____	
Name and Location of the County representative that received this authorization: Kellie Sullivan, Custodian of Records, Marin County Fire Department		Date: