THE CITY OF GRANDVIEW HEIGHTS
DEPARTMENT OF PUBLIC SAFETY
DIVISION OF FIRE

City of Grandview Heights Division of Fire

Authorization for Release / Disclosure of Protected Health Information

I hereby authorize the release or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. By signing this Authorization, I understand that I am giving my authorization to the Grandview Heights Division of Fire to disclose my protected health information as specified in this Authorization. I further understand that if the person or organization I authorize to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal or state privacy regulations.

I authorize the Grandview Heights Division of Fire (GHFD) to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____
Social Security Number: _____
Address: _____
Telephone: _____Incident Date:_____
Complete incident report(s)_____ Exceptions: List below_____
_____

This information is to be disclosed to the following individual or entity:

Name: _____ Relationship: _____
Address: _____
Telephone: _____ Facsimile: _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, that this authorization will expire on __/__/__ or on the happening of _____. Initials: _____
b. I understand that I may revoke this authorization at any time by notifying GHFD in writing, but if I do it will not have any effect on any actions GHFD took before it received the revocation. Initials: _____
c. I understand that GHFD its employees, officers, and physicians involved in my care are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Initials: _____

(Form MUST be completed before signing)

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____
_____
_____

This form must be notarized unless signed in the presence of the Fire Chief or Privacy Officer.