Patient Authorization to Use and Disclose Protected Health Information

Patient Name:_____Phone:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____ Date of Birth:_____

By signing this Authorization, I hereby direct the use or disclosure by Truckee Meadows Fire Protection District of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

_____
_____
_____

This information may be used or disclosed by Truckee Meadows Fire Protection District and may be disclosed to:

_____
_____

I understand that I have the right to revoke this Authorization at any time, except to the extent that Truckee Meadows Fire Protection District has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Truckee Meadows Fire Protection District's HIPAA Compliance Officer:

Compliance Officer:

Mollie Troy

3663 Barron Wy,

Reno, Nv USA

866.539.0874 Ext. 242

Email: molly@rpmbilling.com

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Truckee Meadows Fire Protection District to use my protected health information for treatment, payment, and healthcare operations.

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

_____
_____
_____

The use or disclosure of the requested information will___, /will not _ result in direct or indirect remuneration to Truckee Meadows Fire Protection District 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.

This authorization expires on: (date or event) _____

Signature: _____ Date:_____

Personal Representative information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Description of the authority of personal representative:_____
_____

Street Address:_____ City:_____ State:_____ Zip Code:_____