AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

*[To be used if requesting testimony, appearance at depositions, etc.,
or if requesting medical or billing records]*

PLEASE COMPLETE THE BOXES BELOW

TO:	REGARDING PATIENT:	*if requesting records **RELEASE TO:**
SOUTH METRO FIRE RESCUE **9195 E. MINERAL AVE. CENTENNIAL, CO 80112**	**NAME:** **BIRTH DATE:** **DATE OF SERVICE:**	**NAME:** **ADDRESS:** **EMAIL ADDRESS or FAX NUMBER (If requesting electronic copies):**

BY SIGNING THIS AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (“AUTHORIZATION”), I REQUEST AND AUTHORIZE SOUTH METRO FIRE RESCUE (SMFR) TO RELEASE THE INFORMATION SPECIFIED BELOW PERTAINING TO MY HEALTH, MY HEALTH CARE OR ME TO THE ORGANIZATION, INDIVIDUAL OR AGENCY DESIGNATED ON THIS AUTHORIZATION. THIS AUTHORIZATION IS INTENDED TO INCLUDE ANY AND ALL INFORMATION, BUT IS NOT LIMITED TO, THE FOLLOWING TYPES OF MEDICAL INFORMATION ABOUT ME: INFORMATION REGARDING DRUG ABUSE (IF ANY), SICKLE CELL ANEMIA (IF ANY), SEXUALLY TRANSMITTED DISEASE, AIDS, HIV (IF ANY), ALCOHOL ABUSE OR ALCOHOLISM (IF ANY) AND PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS (IF ANY).

PURPOSE OR NEED FOR WHICH INFORMATION IS REQUESTED: The Authorization is being requested by the patient for the following purpose(s) (Check each box that applies):

____ **TESTIMONY. (Identify case name, number, and date(s) of appearance(s):**
____)

____ **OTHER (describe):** ____

RELEASE OF INFORMATION LIMITED TO DATES AND CONDITIONS AS DESCRIBED (IF NOTHING WRITTEN, NO LIMITATION WILL APPLY): ______________________________
____

SPECIFIC INFORMATION REQUESTED (CHECK EACH BOX THAT APPLIES) (IF NO BOXES ARE CHECKED, ALL RECORDS WILL BE RELEASED):

____ COMPLETE COPY OF SMFR EMERGENCY RESPONSE MEDICAL RECORDS RELATED TO TREATMENT OF THE PATIENT, INCLUDING ANY AND ALL TREATMENT-RELATED CORRESPONDENCE

____ COPY OF ALL BILLING RECORDS

____ **Damage or claim evaluation and presentation**

____ Judicial or administrative proceeding

____ Other (describe):____

AUTHORIZATION: I understand that I am not required to sign this Authorization and that my healthcare will not be affected if I do not sign this Authorization. I further understand that my written authorization is not required for the Authority to use my protected health information for treatment, payment and health care operations or as otherwise required or permitted by law. I certify that I am making this request voluntarily. k I request that this Authorization expire on _____________, 20___. (If no date is assigned, this Authorization will automatically expire one year after the date signed, or when revoked in writing, whichever occurs first.) **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 acknowledge that I have read this Authorization and that I understand and agree to its terms. A copy of this Authorization may be used with the same effectiveness as an original.**

If I have requested SMFR provide electronic copies via E-mail or facsimile, I understand that such records will be sent unencrypted and SMFR cannot guarantee the security of those records.

____________________________________	__________________________	________
Signature of Patient	Printed Name	Date

If a personal representative is signing on behalf of Patient, state how authorized:

____

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____________________________________	___________________________	______
SIGNATURE OF PERSONAL REPRESENTATIVE	**PRINTED NAME**	**DATE**