AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

1. **I AUTHORIZE:**

   Baltimore City Fire Department
   401 E. Fayette St.
   Baltimore, MD 21202

2. **TO RELEASE RECORDS TO:**

   NAME: _____

   ADDRESS: _____

   _____

3. INFORMATION TO BE RELEASED: **Copies of Emergency Medical Services (EMS) Reports.**

4. RECORDS FROM THE TIME PERIOD(S): **_____.**

5. THE PURPOSE OF THIS DISCLOSURE IS: **_____.**

6. DURATION OF AUTHORIZATION: Unless otherwise revoked, this authorization is valid until __/__/__, or for a period of one year, whichever is less.

7. By signing below, I understand and acknowledge the following:

   - That I specifically authorize the disclosure of information pertaining to mental health records, communicable diseases (including HIV and AIDs), and alcohol/drug abuse treatment.
   - That I may revoke this authorization at any time by presenting a written revocation to the Custodian of Records.
   - That I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or the policy itself.
   - That any revocation will not apply to information that already has been released in response to this authorization.
   - That information released pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
   - That if I have any questions about disclosure of my protected health information, I may contact the Custodian of Records.

_____	_____
Patient's Name	Patient's Social Security Number
_____	_____
Street Address	Patient's Date of Birth
_____	_____
Patient's or Representative's Signature	Date
_____	_____
Printed name of patient's representative (if applicable)	Basis of the representative's authority (if applicable – attach relevant documentation)