

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)