CLAYTON COUNTY BOARD OF COMMISSIONERS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name, Social Security Number and Date of Birth of person whose health information will be disclosed:** *[please print]*

Part 2: **Person or Entity that has the health information to be released:**
□ Clayton County Fire Department/EMS Division (ambulance, trip reports/patient care reports)
□ Clayton County Finance Department (ambulance bills)
□ Other: _____ *[please print the name of the entity that has the record to be disclosed]*

Part 3: **Description of the health information to be released:**
□ EMS Trip Report; Patient Care Report Date of reported incident:
□ Ambulance Bill Date of reported incident:
□ Other: _____ *[describe the health information that may be disclosed]*

Part 4: **Person or Entity that will receive the health information:**
□ Person whose name appears in Part 1; Address:
□ Other: _____ *[please print the name and address of the person or entity who will receive the record]*:

Part 5: **Description of the purpose for the release of the health information:**
□ At the request of the person whose name appears in Box 1
□ Other: _____ *[insert description of the purpose]*:

Part 6: **Duration of Authorization:** This Authorization will remain effective *[choose an expiration period or event]*:
Expiration period: □ 30 days □ 60 days □ 90 days □ 180 days □ ___ days
Expiration event: _____ *[insert description of an event upon which the Authorization will expire]*:

Part 7: ***I certify that I am the person (or qualified representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5. I understand that, I am an individual within the meaning of the HIPAA Privacy Rule, a federal law that protects the privacy of my health information. I affirm that this Authorization is voluntary. I understand that EMS may not condition my future treatment on my giving or not giving this authorization. I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity who received the Authorization, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. I have received a copy of my signed Authorization.***

_____ _____

Signature of Individual or his/her Personal Representative Date

<u>If this authorization is signed by a personal representative of the individual, please provide a description of such representative's authority to act for the individual, i.e., a copy of the letters of appointment from the Probate Court, a copy of the power-of-attorney (certified that it is still in effect), etc.</u>

YOU ARE SPECIFICALLY AUTHORIZED TO RELY UPON A
PHOTCOPY OR FACSIMILE OF THIS AUTHORIZATION AS AN ORIGINAL