Authorization to Disclose Or Request Protected Health Information (HIPAA Compliant Authorization Form)

I,_____
Patient's Name (Please print) Patient's Date of Birth (MM/DD/YY) Patient's Phone Number

of _____
Patient's Address

hereby authorize the following Service Provider:

Fredericksburg Fire Department and Rescue Squad
601 Princess Anne St
Fredericksburg, VA. 22401

to disclose and/or receive individually identifiable health information on my behalf: Specifically, the **Fredericksburg Fire and Rescue Privacy Officer** and/or his/her designee, and **MED3000.**

1. The disclosure of the following specific information is authorized: **Patient information related to the emergency medical services currently being provided on this date.**
2. This authorization is in effect for **emergency medical services being rendered on this date.**
3. This authorization allows the indicated service provider to share the specified information for **a single use or disclosure** available at the time of authorization.
4. This information will be used/disclosed for **patient care and transportation billing only.**
5. This authorization allows the receiving medical facility to release my health insurance information for ambulance transport billing only.
6. I understand that:
   - Service providers using or disclosing information based upon this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure identified in **Item 4.**
   - The City of Fredericksburg will not condition the provision of services related to treatment, payment, enrollment, or eligibility for benefits on my decision to sign this authorization.
   - I may revoke (or cancel) this authorization at any time by submitting a **written statement of revocation** to the service provider whose address is provided above, except to the extent that the identified service provider already has taken action based upon this authorization.
   - I have a right to request and receive a **Notice of Privacy Practices** from The City of Fredericksburg
   - The information to be released has been fully explained to me and this authorization is given of my own free will.

7. Please send or communicate the authorized information to the following addresses:

Fredericksburg Fire Dept.
Attention: HIPPA Privacy Officer
601 Princess Anne St
Fredericksburg, VA. 22401

Signature:_____

Relationship to patient: ☐Self ☐ Parent of Minor Child ☐Guardian ☐ Legally Authorized Representative

Date:_____

A copy of this shall be valid as the original.

(Revised 02/16/09)

PRINT