HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I,_____authorize and/or provide authorization to **PUGET SOUND REGIONAL FIRE AUTHORITY** to provide my ***Patient Care Record,*** a medical-related document, hereinafter known as a "Medical Record."

ACKNOWLEDGMENT OF RIGHTS

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that "*Medical Records*" and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

Date: _____

Signature of Patient:_____

Print Name: _____

This authorization will terminate/expire on_____.