Warren County Department of Fire & Rescue Services
200 Skyline Vista Drive, Suite 200, Front Royal, Virginia 22630 Phone: (540) 636-3830

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

The HIPPA Privacy Rules (federal regulations that became effective April 14, 2003) provide important protection for health information including that your authorization must be obtained for release of information in certain circumstances. The Privacy Rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

*INSTRUCTIONS: Fill out form completely and accurately. Be sure to sign this document and mail to Warren County Fire & Rescue along with a copy of any supporting documentation, i.e. Birth Certificate, Power of Attorney, and/or Photo Identification (**Required**). If not completed completely or accurately, this request will be rejected.*

Patients Name: _____ Social Security #: _____ - _____ - _____

Address:_____ City/State/Zip:_____ ___ _____

Telephone: _____ Cell: _____ DOB: _____

I hereby authorize the release of my PHI related to Warren County Fire & Rescue:

SERVICE DATE: _____ CALL NUMBER (if known): _____

Purpose for this disclosure: _____ Insurance _____ Other (please specify)_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers;
- All physical, occupational and rehab requests, consultations and progress notes;
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits;
- All employments, personnel or wage records;
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reel and reports;
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs;
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This PHI is disclosed for the following purposes _____.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State, and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two (2) years from date of execution at which time this authorization expires.

_____ _____
Patient/Representative's Signature Date
(See 45 CFR § 164.508(c)(1)(vi))

_____
Name and Relationship of Authorized Representative to Patient
(See 45 CFR § 164.508(c)(1)(iv))

_____ _____
Witness Signature Date

SIGNATURE AND COPY OF PHOTO ID IS REQUIRED

Method: _____Mailed _____Picked Up _____Faxed Call #: _____

Sent by: _____ Date: _____