Request and Authorization for Disclosure of Health Information Form

City of Miramar Fire Rescue Department

14801 SW 27th St.
Miramar, FL 33027
(954) 602-4852
http://www.miramarfd.org

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a patient has the right to access, inspect and copy their Protected Health Information (PHI) maintained by Miramar Fire-Rescue. Additionally, your rights allow you to request a copy, request to amend and/or request restriction of the use of any disclosure of your PHI.

This is an authorization requesting the City of Miramar Fire-Rescue Department to release medical reports and/or information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or by state law protecting the privacy of health information.

I,_____, hereby authorize the use and disclosure of the individually identifiable health information to be furnished to the requesting party below.

REQUESTING PARTY'S INFORMATION

Name_____ Date of Request_____

Address_____
Apt./Suite # City State Zip Code

Phone Number_____

PATIENT INFORMATION

Name on Report_____

Patient Date of Birth_____ Patient SSN_____

Location of Incident_____ Date of Incident_____

Time of Incident_____ Incident Number (if known)_____

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

_____ _____

Signature of Patient or Personal Representative Print Name

Relationship to Patient _____

STATE OF ___
COUNTY OF_____

The foregoing instrument was acknowledged before me this_____day of _____ , 20__,
by .

Personally Known or Produced Identification Type of Identification Produced_____

(NOTARY SEAL)

Notary Public _____