CITY OF HOUSTON FIRE DEPARTMENT – EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROCTED HEALTH INFORMATION

Read the instruction on page 3 carefully before completing this form

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I. PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY#:	DATE OF BIRTH:	

SECTION II. VOLUNTARY AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, voluntarily authorize the City of Houston, its agents, servants, employees, officials, and
Patient, Legal Guardian, or Authorized Representative
Attorneys to release the following Emergency Medical Service records (i.e., documents, audio and video recording, etc.), maintained by the City of Houston, for the above-referenced patient for medical services provided on _____to person listed in Section IV of this form.
Date of Service

SECTION III. DESCRIPTION OF INFORMATION AUTHORIZED FOR RELEASE *(See* Instructions on Page 3 to complete this section)

- ❑ Entire Emergency Medical Services Record
- ❑ Only information related to (specify)_____
- ❑ Only the period of events from _____to _____
- ❑ Other (specify)_____

If you would like any of the following sensitive information, disclosed, check the applicable box (es) below:

- ❑ Alcohol/Drug Abuse Treatment/Referral
- ❑ Sexually Transmitted Diseases
- ❑ HIV/AIDS-related Treatment
- ❑ Mental Health (other than Psychotherapy Notes)

SECTION IV. NAME AND ADDRESS OF PERSON OR ORGANIZATION TO RECEIVE PATIENT'S HEALTH INFORMATION

PLEASE PRINT

NAME: Ross Reporting Services

ADDRESS:
11706 Playa Court, Houston, Texas 77034

SECTION V. PURPOSE FOR RELEASE *(See* instruction on Page 3 to complete this section)

Please provide the purpose for the use or disclosure:

_____

SECTION VI. EXPIRATION DATE

Please provide a date or event upon which you wish this authorization to expire_____

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed.

SECTION VII. RIGHT TO REVOKE

I under stand that I may revoke or withdraw this authorization, in writing, submitted at any time by submitting revocation to the City of Houston Fire Department – Emergency Medical Services Records Division located at: 601 Sawyer, Suite 720, Houston Texas 77007, except to the extent that the City of Houston Fire Department has already used or disclosed the requested protected health information in reliance on my authorization.

SECTION VIII. PERMITTED REDISCLOSURE

I understand that the information, disclosed under this authorization, is subject to redisclosure by the recipient and is no longer protected health information. I also understand that withdrawal of consent does not affect any information disclosure before the date on which written notice of withdrawal was received.

I understand that authorizing the use or disclosure of the above-identified information is voluntary. I also understand that I do not need to sign this form to ensure health care treatment.

SECTION IX. PHOTOCOPIES OF AUTHORIZATION

I agree that photocopy of this information will have the same effect as the original

SECTION X. CHARGE FOR PHOTOCOPIES OF RECORDS

I understand that the City of Houston will charge for photocopies of the requested record (s) according to the schedule provided by section 2-89 and 2-99 of the City of Houston Code of Ordinances.

SECTION XI. PATIENT'S RIGHT TO REFUSE SIGNATURE AND OBTAIN COPIES

I understand I am entitled to inspect or copy the protected health information to be used or disclosed. I understand I have the right to refuse to sign this authorization and I am willing to sign this authorization.

SECTION XII. AGREEMENT NOT TO SUE THE CITY FOR RELEASE UNDER THIS AUTHORIZATION

I agree not to claim damages or sue the city, or any of its employees or elected or appointed officials, for releasing the medical information as authorized by me in this document.

SECTION XIII. PATIENT'S/AUTHORIZED REPRESENATIVE'S SIGUNATURE AND DATE

PLEASE READ THIS ENTIRE FORM, INCLUDING THE INSTRUCTIONS, CAREFULLY BEFORE SIGNING THIS FORM

SIGNED on this the_____day of _____, 20_____

_____

SIGNATURE OF PERSON CONSENTING TO THE RELEASE OR HIS OR HER RECORDS OR NAMED OF AUTHORIZED REPRESENTATIVE

_____

PRINT NAME AND ADDRESS OF THE PERSON CONSENTING TO THE RELEASE OF RECORDS

NOTE: If the person signing this form is an authorized personal representative's signature, please provide a description of such representative's authority to act for the individual below:

_____

_____

_____

STATE OF TEXAS §

§

COUNTY OF _____ §

BEFORE ME, the undersigned authority, on this day personally appeared _____, whose identity has been proven to me, and who, after being duly sworn did depose, acknowledge and swear that he/she executed the foregoing **CITY OF HOUSTON FIRE DEPARTMENT-EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION** as his/her free act and deed, and that he/she is over the age of eighteen (18) years and is of sound mind.

GIVEN under my hand and seal of office on this ___ day of _____, 20 _____.

(SEAL)

_____

NOTARY PUBLIC AND FOR
THE STATE OF TEXAS

INSTRUCTIONS FOR COMPLETING
THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using blue ink.

2. **Section I**, print name, address, social security number, and date of birth of the patient.

3. **Section II**, print the name of the patient or authorized person. Then fill in the date of service.

4. **Section III**, check the appropriate box as applicable.

   a. **Entire Emergency Medical Services Record** - the complete record except for sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS- related treatment, and mental health other than psychotherapy notes.)

   b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** – specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002

   d. **Other (specify)** – e. g., billing, employee health.

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION INCLUDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES AND MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES); YOU MUST CHECK THE APPROPRIATE BOX.**

5. **Section IV**, print the name and address of the person to whom your health information should be released.

6. **Section V**, state the reason for release of the medical information, e.g., litigation, disability claim, continuing medical care, etc.

   If this release is for litigation purposes, please include the case name, cause number, county or district, and court number.

7. **Section VI**, if a different *expiration* date is desired, specify a new date.

8. **Section XI**, sign and date in the presence of a notary. An authorized representative must include a description of their authority, i.e. legal guardian, power of attorney, etc.

9. A copy of the completed form will be given to the patient.