HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
45 C.F.R. PARTS 160 AND 164

DISCLOSURE AUTHORIZATION FORM

AURORA FIRE RESCUE PATIENT CARE REPORT

***Full Name_____ *Date of Birth_____**

I hereby authorize Aurora Fire Rescue to use or disclose my protected health information related to Patient Care by Aurora Fire Rescue

to_____ for the following purpose:

***(Recipient Name, Address, Phone number)**

The date provided below indicates the date the authorization for release of protected health information may be released.

***Effective Date:_____ *Expiration Date:_____**

_____ **I understand that I may inspect or copy the protected health information**
*****Initial **described by this authorization.**

_____ **I understand that, at any time, this authorization may be revoked, when**
*****Initial **the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.**

_____ **I understand that information used or disclosed, pursuant to this**
*****Initial **authorization, may be subject to redisclosure by the recipient and, if so, may not be subject to federal or state laws governing the use and disclosure of my information.**

I hereby certify that this request to disclose my protected health information related to Patient Care by Aurora Fire Rescue has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____ _____

*Date *Signature of Individual or Representative

*Required