San Jose Fire Department

Authorization for Release of Protected Information

I, _____ , hereby authorize San Jose Fire Department to release the following information:
(Print name of requestor or patient)

Please check appropriate box(es):

☐ **Paramedic Patient Contact Report/ Pre-Hospital Care Report (PCR)**
☐ **Other: _____**

To: _____
(Name and title of facility name to receive information)

_____
(Street Address, City, State, ZIP)

_____
(Telephone Number) (Fax Number)

For the following purposes: _____

This authorization in in effect until _____ (date or event) when it expires.

I understand that by signing this authorization:
I am authorizing the use or disclosure of my individually identifiable health information as described above for the purpose listed.

I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will NOT affect information that has already been used or disclosed.

I have the right to receive a copy of this authorization.

I am signing this authorization voluntarily, and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by: _____ Date: _____

Or signed by Personal Representative:

On behalf of: _____
(Name of requestor or patient)

IDENTIFYING INFORMATION

☐ Copy of photo identification (which shows a signature)

Attached TYPE _____
(e.g., CA Driver's License, CA DMV ID Card, Passport, Government Issued Employee ID)

Number _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

Notarized by: _____

Date: _____

Notary Public Number: _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

If you are not the patient of record, what legal authority do you have to make medical decision for the requestor of records or patient?

☐ Parent ☐ Conservator

☐ Guardian ☐ Executor of Will

☐ Medical Power of Attorney ☐ Other

Note: HIPAA Regulations require us to obtain legal documentation (Birth Certificate, Court Order, Will, etc.) to verify that you are the Parent, Guardian, Conservator, or Executor of the decedent's Will, or have medical decision-making authority for the individual.