Miami Valley Fire District
Authorization for Use or Disclosure of Protected Health Information

Pursuant to the Health Insurance Portability and Accountability act of 1996 (HIPAA) and applicable state law, this authorization form must be completed in its entirety to authorize the Miami Valley Fire District to disclose protected health information ("PHI").

Date Submitted:____________________

Patient Name:_________________________________ Date of Birth:_____________________

Incident Date:______________________ Incident Location:_____________________________

I, my personal representative, or person authorized to act on my behalf regarding medical records, authorize Miami Vally Fire District to use and/or disclose the PHI corresponding to the incident above to the following individual or organization:

Name: ____

Address: ____

____

Disclosure Purpose: ____

I retain the right to revoke this Authorization in writing at any time prior to the disclosure by contacting the Miami Valley Fire District. The information disclosed by this authorization may be redisclosed by the recipient and is no longer protected by the HIPAA or applicable state law. This authorization is valid for one year from the date submitted to Miami Valley Fire District.

____
Signature of patient (or personal representative)

____
Printed name of patient (or personal representative and their relationship to patient)

____
Date

Identity Verification

State of ________________________

County of ______________________ , SS:

Having first been duly cautioned and sworn, I hereby do swear that I am the patient stated above, a personal representative of the patient as defined by Ohio Revised Code 3701.74, or have been authorized in writing by the patient within one year of the date of this authorization to act on the patient's behalf with regard to medical records.

____
Relationship to Patient (if not the patient)

____ ____
Signature Printed Name

On this ________ day of ______________, 20 ___, the above-named individual appeared before me and swore that the forgoing is true to the best of his or her knowledge and belief.

____
Notary Public

My Commission Expires:__________________

Identity Verification *(District Use Only)*	
Form of Identification:	____
Relationship to Patient (if not the patient):	____
__________________________________ Released By (Signature)	____ Released By (Printed Name)