

**Authorization For Use And Disclosure Of Protected Health Information (PHI)**

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

For an incident occurring on the date of: \_\_\_\_\_ Approximate time: \_\_\_\_\_

At the location of: \_\_\_\_\_

I hereby voluntarily authorize **Las Vegas Fire & Rescue (Provider)** to disclose the PHI of the above named individual to the following persons or organizations (list name and address for each recipient) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The undersigned hereby gives consent to Las Vegas Fire & Rescue to provide **complete copies of medical records and billing statements** on the terms and conditions set forth pursuant to HIPAA. The type of information to be disclosed will include but is not limited to medical history, problems, allergies, medications, vital signs, nature of injuries and treatment.

I understand that the released information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse; I acknowledge and hereby consent to such.

I understand that if the organization authorized to receive the information is not a health plan or health care provider; the information may be further disclosed and is no longer protected by federal privacy laws and regulations.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment.

I have a right to receive a copy of this authorization. I may inspect or obtain a copy of my health information upon the proper notification to and under the conditions established by the Provider.

A photocopy of this authorization is as effective and valid as the original.

The **expiration date** of this authorization is **1 year** from the date of the signature below.

I understand that this authorization may be revoked by me at any time **except** to the extent that action has already been taken in reliance upon it. I understand that to revoke this Authorization, I must give written notice to the Provider.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is unable to consent by reason of age or some other factor, state reason \_\_\_\_\_

\_\_\_\_\_  
Signature of Legally Authorized Representative      Date      Relationship to Patient

SUBSCRIBED and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public in and for said County and State