PALM BEACH COUNTY FIRE RESCUE (PBCFR)

FORM 10: PATIENT AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by Palm Beach County Fire Rescue of certain protected health information (PHI) pertaining to the patient listed above. The Authorization concerns the following information about the patient:

_____

_____

_____

This information may be used or disclosed by Palm Beach County Fire Rescue and may be disclosed to:

_____

_____

_____

I understand that I have the right to revoke this Authorization at any time, except to the extent that Palm Beach County Fire Rescue has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Palm Beach County Fire Rescue's HIPAA Compliance Officer or to the County HIPAA Privacy Officer:

PBCFR HIPAA Compliance Officer - Melissa Behn
405 Pike Road
West Palm Beach, Florida 33411
(561)616-7025
legalliaison@pbcgov.org

Or

County HIPAA Privacy Officer for PBCFR – Sharon Burrows
301 North Olive Avenue,
West Palm Beach, Florida 33401
(561) 355-4392

Nbolton@pbcgov.org

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Palm Beach County Fire Rescue to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Palm Beach County Fire Rescue for the following purpose(s):

_____
_____
_____
_____

The use or disclosure of the requested information will ____/will not ____ result in direct or indirect remuneration to Palm Beach County Fire Rescue from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ Date:_____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____

Description of the authority of personal representative:
_____

Street Address: _____

City: _____ State: _____ Zip Code: _____