Patient Authorization

Sonoma County Fire District
Patient Authorization to Use and 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 Sonoma County Fire District of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

_____

_____

_____

This information may be used or disclosed by Sonoma County Fire District and may be disclosed to:

_____

_____

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

David Bynum
8200 Old Redwood Highway
PO BOX 530
Windsor, CA 95492
707-892-2014
dbynum@sonomacountyfd.org

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

I understand that my written authorization is not required for Sonoma County Fire District 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 Sonoma County Fire District for the following purpose(s):

_____

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Sonoma County Fire District 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).

Method of Delivery of Requested Information

Please indicate how you would like to receive the information you are requesting:

☐Email – Please provide your email address:_____

☐Mail – Please provide your mailing address: _____

☐Other – Please specify:_____

Note: By choosing email, you acknowledge that while we will use reasonable safeguards, this method may not be fully secure. You may request alternative secure methods if preferred.

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: _____