Jeffrey M. Happ
Fire Chief

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DIVISION OF FIRE

AUTHORIZATION FOR USE AND 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 Columbus Division of Fire to disclose protected health information.

DATE SUBMITTED: __________________

Patient Name: ______________________________

Incident Date: ______________________________

Incident Location: ______________________________

Incident Number: ______________________________

I, my personal representative, or person authorized to act on my behalf regarding medical records, authorize the Columbus Division of Fire to use or disclose the patient care report(s) corresponding to the incident(s) above to the following individual or organization:

Name: ______________________________

Address: ______________________________
____

Disclosure Purpose: ______________________________

Expiration Date or Event: ______________________________

You retain the right to revoke this Authorization in writing at any time prior to the disclosure by contacting the Columbus Division of Fire, EMS Records Office. The Division of Fire does not condition treatment upon the signing of this Authorization. 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 CFD.

______________________________ ______________
Signature Date

____
Printed Name

Jeffrey M. Happ
Fire Chief

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 (*Division Use Only*)	
Form of Identification:	______________________________
Relationship to Patient (if not the patient):	______________________________
______________________________ Released By (Signature)	______________________________ Released By (Printed Name)