SAN FRANCISCO FIRE DEPARTMENT

Authorization for Release of Medical & Billing Records

STATEMENT OF EXPLANATION
Completion of this document is necessary to authorize the San Francisco Fire Department (SFFD) to release your confidential and protected health information to another person or entity as required by federal and California state laws concerning the privacy of such information. **FAILURE TO PROVIDE THE REQUESTED INFORMATION MAY INVALIDATE THE AUTHORIZATION AND PREVENT THE SAN FRANCISCO FIRE DEPARTMENT FROM ACTING IN RELIANCE ON THIS AUTHORIZATION.**

PATIENT INFORMATION		
Last Name:	First Name:	Date of Birth:
Address:	City/State:	Zip Code:

ORGANIZATION PROVIDING INFORMATION		
Name of Organization: **SAN FRANCISCO FIRE DEPARTMENT - EMS, CUSTODIAN OF RECORDS**		
Address: **1415 EVANS AVE.**	City/State: **SAN FRANCISCO, CA**	Zip Code: **94124**

INFORMATION TO BE RELEASED

Incident Date: _____

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.

I hereby authorize the disclosure of the following information pertaining to the incident date above:

- ☐ My entire MEDICAL Record and any accompanying documents
- ☐ My MEDICAL Record limited to: _____
- ☐ My entire BILLING Record
- ☐ My BILLING Record limited to: _____

INFORMATION TO BE RELEASED

PROTECTED CLASS INFORMATION

Special approval, as required by law, is needed before the protected classes of information listed below can be released. These types of information may or may not be contained in your medical record.

To approve the release of your <u>entire</u> medical record, you must initial all spaces below.

Initial in the appropriate space(s) as indicated for approval of disclosure

____ Mental Health Treatment ____ Substance Abuse Treatment

____ HIV/AIDS Test/Treatment ____ Developmental Disabilities

____ Sexually Transmitted Disease Treatment

ORGANIZATION RECEIVING INFORMATION

Name of Organization:	Name of Requestor:	Phone Number:
Address:	City/State:	Zip Code:

Information used or disclosed pursuant to this authorization may be subject to further disclosure by recipients not covered by federal HIPAA regulations. Although disclosed information may no longer be subject to federal privacy protections, state law requires recipients to refrain from re-disclosing such information unless another written authorization is obtained or specifically required by law.

DESCRIPTION OF PURPOSE

The purpose of this authorization is for:

☐ Preparing the litigation of a claim on behalf of the above patient, pursuant to California Evidence Code §1158

☐ Other: _____

_____

Each purpose listed above must be consistent with actual use. Supporting documentation may be submitted with authorization to substantiate purpose of use and disclosure.

EXPIRATION OF AUTHORIZATION

This authorization expires on: (date/event) _____
If no expiration given, this authorization will expire 90 days from the signature date below.

REVOCATION OF AUTHORIZATION

I understand that I have the right to revoke this authorization at any time except to the extent that SFFD has already acted in reliance on this authorization. To revoke this authorization, I understand that I must do so by submitting a written request to:

Compliance Officer
San Francisco Fire Department, EMS Division — Phone: (415) 558-3384
698 Second Street — FAX: (415) 558-3407
San Francisco, CA 94107 — FireHIPAA@sfgov.org

The authorization will stop on the date the request to revoke the authorization is received.

PATIENT SIGNATURE

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that SFFD is prohibited from creating any conditions to treatment or payment based on me signing or not signing this authorization unless otherwise specified in this authorization. I acknowledge that I have read the provisions in this authorization and I have received a copy. I understand and agree to the terms of this authorization.

Patient Signature:	Date:

Representative Name:	Relation to Patient:	Translator Used: ☐ Yes ☐ No

If you are NOT the patient but are acting on behalf of the patient, provide your name and relation to the patient. Patient representation is acceptable ONLY if the patient is unable to make the request when given the opportunity. A representative is defined as next-of-kin, power of attorney for health care, or the one who is legally entitled to make medical decisions on behalf of the patient. Legal representatives must provide proof of medical or health care power of attorney for the authorization to be valid.

Photocopies of this authorization will be considered as valid as the original.