



**Authorization to Use & Disclose Protected
Health Information**

This authorization allows the release of protected health information pursuant to 45 Code of Federal Regulations (CFR) sections 160 and 164, and any information considered sensitive covered under 42 CFR. The Sierra Fire Protection District is hereby authorized to disclose protected health information as described below pertaining to the course of treatment for:

Patient First Name: _____
Patient Last Name: _____
Patient Address: _____
Patient Date of Birth: _____
Date of Treatment: _____
Time of Treatment: _____
Address of Treatment: _____
Incident # or Location if Known: _____

1. Persons/Organizations Authorized to Receive the Information

Name: _____
Address: _____
Purpose: _____

2. Purpose of Requested Use or Disclosure

Please specify in detail all the information being requested: _____

3. Additional Authorization:

The following must be initialed to be included in the use and/or disclosure

HIV/AIDS-related information and/or records Initials: _____

Mental Health treatment information and/or Initials: _____

Genetic testing information and/or records Initials: _____

Drug/Alcohol diagnosis, treatment or referral information Initials: _____

(Federal regulations require a description of how much and what kind of information is to be disclosed.)

4. Expiration

This authorization will automatically expire one year from the date signed below or on _____, 20____.

5. Revocation

It is understood that I have the right to revoke the authorization at any time (prior to its expiration), and it may only be revoked in writing by hand-delivering a copy of the same or sending by certified mail to the Sierra Fire Protection District. I further understand that I have the right to stop the use or release of information at any time but understand that I cannot do anything about information already used or disclosed under this authorization.

6. Re-Disclosure

I understand that the information used or disclosed in accordance with this authorization may not longer be protected by federal law and could be used or re-disclosed by the receiving party. I further understand that information obtained by use of this authorization may be re-disclosed in the litigation known as:

_____.

7. Refusal to Sign

I understand that I may refuse to sign this authorization and that the above-named medical provider will not condition treatment on whether I sign this authorization.

8. Copy

I understand that I have a right to receive a copy of this authorization if so desired.

9. Certification

I certify that I am (check which box appropriately applies)

The patient, and the identification I have provided is true and

The patient's authorized representative, and the identification and proof of authority that I have provided is true and correct. My relationship to the patient is that of: _____.

Dated this _____ day of _____, 20__.

Signature

Printed Name

State of _____

County of _____

This instrument was acknowledge before me _____, 20__
by _____.

(Signature of Notary Officer)

Please send form via certified mail with the original, notarized form, along with the Incident Report Form, to the:
Office of the County Manager
Attention Sierra Fire Protection District
1001 E Ninth St
P.O. Box 11130
Reno, NV. 89520-0027