Form 25: **Patient Authorization**

Hyannis Fire Department
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 Hyannis Fire Department of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

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This information may be used or disclosed by Hyannis Fire Department and may be disclosed to:

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

Michael Medeiros
95 High School Rd. Ext.
Hyannis, Ma. 02601
508-775-1300
mmedeiros@hyannisfire.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 Hyannis Fire Department 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 Hyannis Fire Department for the following purpose(s):

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The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Hyannis Fire Department 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:

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____

Street Address: ____

City: ___________________________State: ______________ Zip Code: _____________