



**AUTHORIZATION FOR USE & DISCLOSURE
OF PROTECTED HEALTH INFORMATION AND RECORDS**

*Watsonville Fire Department (WFD)
Medical Release*

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq.* (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 *et seq.*].

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

If you have any questions about this authorization, please contact the Custodian of Records, Watsonville Fire Department, 372 Airport Blvd., Freedom, CA 95019, (831) 768-3200.

PLEASE PRINT LEGIBLY

I, _____ hereby authorize Watsonville Fire (WFD) to disclose the protected health information and records of:

Patients Name: _____ Patients Date of Birth: _____

To be released to (select one): self personal representative

For the purpose of: _____

Incident Date: _____ Incident Time: _____

Incident No. (assigned by WFD, not by law enforcement): _____

Address/Location, with nearest cross street (if known): _____

This authorization is limited to the following information relating to my past, present, or future physical or mental health or condition:

Complete health record(s) and other records for the following date of service, which may contain all of the documents listed below, as well as other notes/documents relating to my treatment:

Complete health record(s) and other records for the following date of service, excluding the following records:

The following health records or other records: _____



**AUTHORIZATION FOR USE & DISCLOSURE
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Watsonville Fire Department (WFD) Medical Release (Continued)

EXPIRATION

This authorization shall be in force and effect until _____, at which time this authorization to disclose this protected health information and records expires.

PATIENT'S RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Custodian of Records, Watsonville Fire Department, 115 Second Street, Watsonville, CA 95076. I understand that a revocation is not effective to the extent that WFD has relied on the use or disclosure of the protected health information.

WFD will not condition my treatment on whether I provide authorization for the requested use or disclosure, unless as otherwise specifically allowed by law.

I understand that California law prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law. However, if the recipient of my health information is not located in California, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law or by the law of the state in which the recipient is located.

I understand that I have a right to receive a copy of this authorization upon my request. In addition, if WFD has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

_____ Initials of Custodian of Records that a copy of the release was provided.
INITIALS

Signature of Patient or Personal Representative

Date (month/date/year)

Print Name of Patient or Personal Representative

NOTE: If signed by a Personal Representative of the Patient, please complete the *Affidavit In Support of Request for WFD Medical Records*



**AUTHORIZATION FOR USE & DISCLOSURE
OF PROTECTED HEALTH INFORMATION AND RECORDS
AFFIDAVIT IN SUPPORT OF REQUEST FOR WFD MEDICAL RECORDS**

I, _____ DECLARE AS FOLLOWS:

1. I am the personal representative or beneficiary of _____.
(name of person whose records you are seeking)

 2. The authority for me to act in that capacity is as follows [**please provide a copy of any document(s) that you have which grant you authority to request the subject records**]:
 - I am the legal guardian.
 - I am acting pursuant to a durable power of attorney.
 - I am the conservator of the person.
 - I am the executor of the estate of the person whose records are sought.
 - Other (please describe): _____
 - If the records are of a decedent, at least 40 days have elapsed since the death of the decedent, and no proceeding is now being or has been conducted for administration of the decedent's estate.
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3. If the records are of a decedent, at least 40 days have elapsed since the death of the decedent, and no proceeding is now being or has been conducted for administration of the decedent's estate.
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4. On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS.
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5. The foregoing is true and correct of my own personal knowledge.

I declare under penalty of perjury that the foregoing is true and correct. Executed at:

(city, state) Date: _____
(month/day/year)

Print Name

Signature