AUTHORIZATION ALLOWING SHERIDAN FIRE DISTRICT TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME: _____

SSN #: _____ **DATE OF BIRTH:** _____

GROUP NAME: _____ **GROUP #:** _____

I authorize Sheridan Fire District to use and disclose a copy of my protected heath information to:

_____

(Name and address of recipient or class of recipients)

for the purpose of:

(Describe each purpose of the use/disclosure)

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in a health plan or eligibility for health benefits.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this Authorization, please send a written statement to the Sheridan Fire District 230 SW Mill St. Sheridan, OR 97378. *and state that you are revoking this Authorization.*

Unless revoked, this Authorization will/shall be in force and effect until the following (check one):

Date: _____ (not to exceed 24 months), OR.

Event: _____

I have reviewed and I understand this Authorization.

By: _____ Date: _____
(Individual)

~OR~

By: _____ Date: _____
(Individual's representative)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

ALL FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID