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

_____

_____

_____

This information may be used or disclosed by Suwannee County Fire Rescue and may be disclosed to:

_____

_____

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

Tim White
13530 80th Terrace
Live Oak, FL 32060

Office: 386-364-3404
Fax: 386-364-1256
timw@suwcounty.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 Suwannee County Fire Rescue 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 Suwannee County Fire Rescue for the following purpose(s):

_____

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Suwannee County Fire Rescue 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.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____