



CITY OF HOUSTON FIRE DEPARTMENT - EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Read the instructions on page 3 carefully before completing this form.

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I. PATIENT INFORMATION

Form with fields for LAST NAME, FIRST NAME, MIDDLE INITIAL, ADDRESS, CITY/STATE, ZIP CODE, SOCIAL SECURITY or OTHER IDENTIFICATION#, and DATE OF BIRTH.

Section II. Voluntary Authorization to Release Medical Services Records

I, _____, voluntarily authorize the City of Houston, its agents, Patient, Legal Guardian, or Authorized Representative servants, employees, officials, and attorneys to release, to person listed in Section IV of this form, the following Emergency Medical Service records (i.e., documents, audio and video recordings, etc.), maintained by the City of Houston, for the above-referenced patient for medical services provided on _____ Date of Service

Section III. Description of Information Authorized for Release (See Instructions on Page 3 to complete this section.)

- a. [] Entire Emergency Medical Services Record, except sensitive information described in (e) below.
b. [] Only information related to (specify): _____
c. [] Only records related to events during the period from _____ to _____
d. [] Other (specify): _____
e. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
[] Alcohol/Drug Abuse Treatment/Referral [] HIV/AIDS-related Treatment
[] Sexually Transmitted Diseases [] Mental Health (Other than Psychotherapy Notes)

Section IV. Name and Address of Person or Organization to Receive Patient's Health Information

(Please Print)

Name: Discovery Resource
Address: 1511 West 34th Street
Houston, Texas 77018

Section V. Purpose for Release (See attached instructions):

Please provide the purpose for the use or disclosure:

Section VI. Expiration Date or Event

Please provide a date or event upon which you wish this authorization to expire: _____

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed. If you choose to specify an expiring event, you must provide the City with an actual date at the time that this authorization is signed or by written notice sent to: City of Houston Fire Department - Emergency Medical Services Records Division located at: 500 Jefferson, Suite# 1600, Houston, Texas 77002. If the City does not receive written notice containing the actual date of expiration, the City will continue to rely on this authorization for one year from the date it was signed.

**INSTRUCTIONS FOR COMPLETING THE
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

1. Print legibly in all fields using blue ink.

2. **Section I**, print name, address, social security number, and date of birth of the patient.

3. **Section II**, print the name of the patient or authorized person. Then fill in the date of service.

4. **Section III**, check the appropriate box as applicable.

a. **Entire Emergency Medical Services Record** - the complete record except for sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

c. **Only the period of events from** - specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002.

d. **Other (specify)** - e.g., billing, employee health.

e. **IN ORDER TO RELEASE SENSITIVE INFORMATION INCLUDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU MUST CHECK THE APPROPRIATE BOX.**

5. **Section IV**, print the name and address of the person or organization to whom your health information should be released. The person or organization authorized to receive your health information should provide you with a copy of the completed Emergency Medical Services Authorization for Release of Protected Health Information.

6. **Section V**, state the reason for release of the medical information, e.g., litigation, disability claim, continuing medical care, etc.

If this release is for litigation purposes, please include the case name, cause number, county or district, and court number.

7. **Section VI**, if an *expiration* date other than one year from signature is desired, specify an expiration date in the space provided.

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed.

If you choose to specify an expiring event, you must provide the City with an actual date at the time that this authorization is signed or by written notice sent to: City of Houston Fire Department - Emergency Medical Services Records Division located at: **500 Jefferson, Suite# 1600, Houston, Texas 77002**. If the City does not receive written notice containing the actual date of expiration, the City will continue to rely on this authorization for one year from the date it was signed.

8. **Section XIII**, sign and date in the presence of a notary. An authorized representative must include a description of their authority, i.e. legal guardian, power of attorney, etc.

If the person signing this form is an authorized personal representative, please provide a description of such representative's authority to act for the individual below **and**, if other than a parent of a minor or dependent child, attach a copy of the power of attorney, evidence of guardianship, or other document authorizing representation.