AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

Ventura County Fire Protection District (VCFPD) 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, Ventura County Fire Protection District, 165 Durley Avenue, Camarillo, California, 93010, (805) 383-4718.

PLEASE PRINT LEGIBLY

I, _____, hereby authorize Ventura County Fire Protection District (VCFPD) to disclose the protected health information and records of:

Patient's Name:_____ **Patient's Date of Birth**: _____

To be released to (select one): ☐ myself or ☐ my personal representative

Incident Date:_____ **Incident Time** (if known): _____

Incident No. (assigned by VCFPD, *not* by the CHP/police): _____

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

_____ **City** _____

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**: _____

_____

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 the Records Department at Ventura County Fire Protection District, 165 Durley Avenue, Camarillo, California 93010. I understand that a revocation is not effective to the extent that VCFPD has relied on the use or disclosure of the protected health information.

VCFPD 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 VCFPD 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.

SIGNATURE

_____ Date:_____
Signature of Patient or Personal Representative (month/day/year)

_____
Print Name of Patient or Personal Representative

<u>NOTE</u>: If signed by a Personal Representative of the Patient, please complete the *Affidavit In Support of Request for VCFPD Medical Records* on page 3:

AFFIDAVIT IN SUPPORT OF REQUEST FOR VCFPD 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 follow [please provide a copy of any document(s) that you have which grants 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)_____
   _____.
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.

4. On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS.

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

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

Print Name and Affix Signature