Decatur Fire Department
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Authorization to Disclose Health Information

Name: _____
Health Record Incident Number: _____
Date of Birth: _____
Date: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following organization to make the disclosure:
   City of Decatur Fire Department
   230 East Trinity Place
   Decatur, Ga. 30030
3. The type and amount of information to be used or disclosed is as follows:
   ___ Medical First Responder Report. Incident Date: _____
4. This information may be disclosed to and used by the following organization:
   City of Decatur Fire Department
5. I understand that I have to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Decatur Fire Departments Privacy Officer.
   I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
   Unless otherwise revoked, this authorization will expire on the following date, event or condition: 30 days from document date.
   If no expiration date, event or condition is specified, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure or information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact the Decatur Fire Departments Privacy Officer @ 404-370-4166.
7. I authorize the following persons, classes of persons or entities, to receive my Protected Health Information (PHI)

Signature of employee, plan participant, or legal representative:

Date:

If signed by legal representative, authority to act for employee/ plan participant:

_____

_____

Signature of Witness: _____