AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

TO: Mt. Charleston Fire Protection District
4650 Kyle Canyon Road, Las Vegas, NV 89124

This authorization allows the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164, and any information considered sensitive under 42 CFR. The above-named medical provider is hereby authorized to disclose Protected Health Information as described below pertaining to the course of treatment for:

Patient Name: _____
Address: _____
Date of Birth: _____
Social Security #: _____
Date of Treatment: _____
Time of Treatment: _____
Address of Treatment: _____
Incident # if Known: _____

1. Persons/Organizations Authorized To Receive the Information

The information is to be used and disclosed to for the purpose of:

Name: _____
Address: _____
Purpose: _____

2. Purpose of Requested Use or Disclosure

The information to be used or disclosed is all information regarding my condition when under your observation or treatment including admittance and discharge papers, patient history, assessments, treatment plans, all physician-dictated reports, reports of operation, consultation reports, radiology reports (x-ray reports), cardiology reports, pathology reports, all laboratory tests and toxicology reports, diagnosis and/or prognosis as to subsequent or future developments, treatment plans, progress notes, nurses' notes, medication records, and billing statements.

3. The following items must be initialed to be included in the use and/or disclosure:

☐ HIV/AIDS-related information and/or records Initials: _____
☐ Mental health treatment information and/or records Initials: _____
☐ Genetic testing information and/or records Initials: _____
☐ Drug/Alcohol diagnosis, treatment or referral information Initials: _____

(Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe:

_____

4. Expiration

This authorization will automatically expire one year from the date signed below or on

_____ , 20___ .

5. Revocation

In understand that I have the right to revoke the authorization at any time (prior to its expiration), and it may only be revoked in writing by hand-delivering a copy of the same or sending by certified mail to The Clark County Fire Department. I further understand that I have the right to stop the use or release of information at any time but understand that I cannot do anything about information already used or disclosed under this authorization.

6. Re-disclosure

I understand that the information used or disclosed in accordance with this authorization may not longer be protected by federal law and could be used or re-disclosed by the receiving party. I further undertand that information obtained by use of this authorization may be re-disclosed in the litigation known as: _____ .

7. Refusal to Sign

I understand that I may refuse to sign this authorization and that the above-named medical provider will not condition treatment on whether I sign this authorization.

8. Copy

I understand that I have a right to receive a copy of this authorization if I so desire.

9. Certification

I certify that I am (check which box applies):

☐ The patient, and the indentification I have provided is true and correct.

☐ The patient's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the patient is that of: _____.

DATED this _____ day of _____ ,20__.

_____
Signature

_____
Printed Name

(INSERT NOTARY HERE)

Please mail original, notarized form, along with Incident Report Request Form, to the address at the top of this form.