Authorization to Use and Disclose Specific Protected Health Information

P: (206) 772-1430
F: (206)772-6095
E: admin@kcfd20.org
W: king20fire.org

By signing this Authorization, I hereby direct the use or disclosure by King County Fire District 20 (KCFD 20) of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

____

____

____

This information may be used or disclosed by KCFD 20 and may be disclosed to:

____

***(List all names or specific identification of the person(s) or class of persons to whom you make the requested use/disclosure)**

I understand that I have the right to revoke this Authorization at any time except to the extent that KCFD 20 has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to KCFD 20's HIPAA Compliance Officer at:

King County Fire District 20 Attn: HIPAA Compliance Officer 12424 76th Ave S
Seattle, WA 98178

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for King County Fire District 20 to use my protected health information for treatment, payment and health care 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 KCFD 20 for the following purpose(s):

The use or disclosure of the requested information will____/will not_____result in direct or indirect remuneration (payment/reward for goods or services) to KCFD 20 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.

Printed Name: ____ Date: __________

Signature ____

Description of the authority of personal representative, if applicable:

This Authorization expires on: _________________ (Date or event)

Administrative note: **A copy of this Authorization MUST be provided to the individual**. This Authorization is not needed in most patient cases since authorization is not required to use Personal Health Information (PHI) for treatment, payment or health care operations. Also, check to see if there are additional requirements, depending on the use of the PHI, such as when you request the authorization for your own use, or when you request the authorization for another covered entity or if the use or disclosure is for research purposes.

King County Fire District #20 | 12424 76th Ave. S. Seattle, WA 98178 | (206) 772-1430