AUTHORIZATION FOR RELEASE OF PATIENT CARE REPORT OR NON-TRANSPORT PCR

For the Use and Disclosure of Protected Health Information

PLEASE PRINT

Patient Information:

_____

Name

_____ _____

Address **Apt. No.**

_____ _____ _____

City **State** **Zip**

_____ _____

Date of Birth **Date of Treatment**

_____ _____

Location of Incident **Hospital Transported To**

_____

Ambulance Number/Engine Number

By signing this Authorization Form, I understand that I am giving my authorization to the City of Chicago Fire Department to use and/or disclose my protected health information (PHI). **I specifically authorize the use and disclosure of PHI pertaining to a <u>Patient Care Report or Non-Transport PCR</u> to the following:**

_____

Name/Organization

_____ _____

Address **Apt. No.**

_____ _____ _____

City **State** **Zip**

_____

Telephone Number

I specifically authorize the use and disclosure of the following:

9 Drug Treatment/Abuse
9 Alcohol Treatment/Abuse
9 Domestic Violence
9 Sickle Cell Anemia
9 Mental Health/Psychiatric
9 HIV/AIDS
9 Sexually Transmitted Diseases

I specifically authorize this use and disclosure for the following purpose: _____
_____.

This authorization shall expire on the 180th day after the signing or as specified _____
_____.

I may revoke this authorization at any time by notifying the City of Chicago in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed by the City of Chicago before the City received the written notice of revocation.

I understand that a potential exists that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary, and I may refuse to sign this Authorization form.

I understand that the City of Chicago's health care component may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the treatment is research-related.

I understand that I have the right to be provided with a copy of this signed authorization form.

_____ _____

Signature of patient or personal representative | Relationship to patient (if applicable)

_____ _____

Printed name of patient | Printed name of personal representative (if applicable)

_____

Date

Subscribe and Sworn
This _____ day, of
_____, 20_____

_____

Notary Seal