Authorization for Release of

Protected Health Information (PHI)

Date:_____

Patient Name:_____ Date of Birth:_____

Address:_____

Requesting Party (if other than Patient):_____

Relationship to Patient:_____

Address:_____

Phone Number:_____Fax Number (if report is to be faxed):_____

Incident Address/Location:_____

I acknowledge that a copy of the Thornton Fire Department's Privacy Notice Form has been provided to me, and that I have had the opportunity to address any questions that I have with a Privacy Officer about the privacy practices of the Thornton Fire Department.

Signature of Patient/Legal Guardian:_____

_____ To access existing PHI for the time frame of _____ (date of service).

I would also like to request that the following parties receive access to the necessary PHI in order to carry out my requested action (please initial below):

_____ To facilitate pursuit of a filed complaint. I authorize the following individuals to receive access to the minimum necessary information specific to the field complaint dated _____:

Initials	Individual's Name	Purpose for Involvement
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ To Amend, Restrict or Account for PHI, all parties involved in treatment, payment or healthcare operations of this patient specific to the field request dated _____.

Fire Department Use Only

Request Received by:_____

Identity Confirmed by: Driver's License Passport Birth Certificate POA Notarized Release Other Government issued Photo ID_____ Other_____

Identity of Legal Guardianship Confirmed by: Legal Power of Attorney Medical Power of Attorney Advanced Directive_____ Other_____

Documents provided:_____ Date Processed:_____ via: Fax Mail In-person

Signature of Privacy Officer:_____