



King County Fire District #2

900 SW 146th Street

Burien, WA 98166

P: (206) 242-2040 | F: (206) 433-6042

Specific Protected Health Information

Authorization to Use and Disclose

Date _____

By signing this Authorization, I hereby authorize and direct the use or disclosure by King County Fire District 2 of certain medical information (PHI) pertaining to my health, my health care, or information regarding me.

This Authorization concerns the following medical information about me:

Response Date: _____ **Response Location:** _____

***Patient Name:** _____

This information may be used or disclosed by King County Fire District 2 and its business associates and may be disclosed to:

List name or specific identification of the person (s) or class of persons to whom the requested use/disclosure may be made

I understand that I have the right to revoke this Authorization at any time except to the extent that the Fire District has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the District Privacy Officer [**Charles Chen, Finance Manager 900 SW 146th, Burien, WA 98166, (206) 242-2040**].

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law. I understand that my written authorization is not required to use my protected health information for treatment, payment/billing purpose, and health care operations. I understand that I have the right to inspect and copy my PHI. The Authorization is being requested for the following purpose(s):

The use or disclosure of the requested information, will ___ or will not ___ result in direct or indirect remuneration to the Fire District 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.

***Patient Signature** _____ **Drivers License #** _____

Date _____ **Contact Phone # :** _____

Description of the authority of personal representative, if applicable, a copy of power of attorney for deceased patient _____

This authorization expires on: _____ (date or event)

For Internal Office Use Only

Date received: _____ () Request Approved () Request Denied

Explanation of Denial: _____

Reviewed/Approved by: _____ **Release Date:** _____

Incident #: _____

If applicable: # of Pages _____ Amount Charged _____ Fee Paid By: () Cash () Check Receipt# _____