|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REQUESTER: Complete the information below *(all sections must be filled in)*. PLEASE PRINT.** | | | | |
| **1. Patient for whom the disclosure of protected health information is being requested** | | | | |
| FIRST MIDDLE LAST MM DD YYYY  Name: Date of birth: / / | | | | |
| Address: | | | | |
|  | | | | |
| Telephone #: Email Address: | | | | |
| **2. I authorize the release of the following information: *(check all applicable)*** | | | | |
| * Transport records | * Billing Records | | | * All records |
| * Other *(describe specifically)*: | | | | |
| These records are for services provided on the following date(s): | | | | |
| **3. Identify who may disclose or use your protected health information.** | | | | |
| * The City of Fairfax Fire Department or an authorized third party may disclose/release my records. | | | | |
| **4. Please send my records listed in #2 above to: *(use additional sheets if necessary)*** | | | | |
| Name: | | | Name: | |
| Address: | | | Address: | |
|  | | |  | |
| Phone: | | | Phone: | |
| Fax: | | | Fax: | |
| Email: | | | Email: | |
| **5. I authorize The City of Fairfax Fire Department to release my protected health information via the following method(s):** | | | | |
| * Email\* * Postal Mail\* | | * Fax\* * Pick Up | | |
| *\*Note: These methods of record transfer may or may not be secure.* | | | | |
| **6. I understand that after the City of Fairfax Fire Department discloses my health information, privacy laws may no longer protect it.** | | | | |
| **Signature of Patient or Representative Date** | | | | |
| **Patient’s Name (printed)** | | | | |
| **Name of Personal Representative** (if applicable)\*\* | | | | |
| \*\* Description of personal representative’s relationship to patient and authority to act for the patient must be provided if personal representative involved: | | | | |
| Add rep contact info | | | | |
| **7. Notary Information (May be used in place of providing government-issued photo identification)** | | | | |
| COMMONWEALTH OF VIRGINIA  CITY OF FAIRFAX, to wit:    Acknowledged before me this \_\_\_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_\_\_.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Notary Public  My Commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_\_\_\_\_. | | | | |
| You can revoke this authorization in writing by sending your request to the address below. You may not be able to revoke this authorization under some circumstances. For more information, see the *City of Fairfax Notice of Privacy Practices* on our website at *www.fairfaxva.gov/government/fire-department* and click the Operations tab, then the *EMS Transport Billing Information* link. Questions can also be emailed to *emsbilling@fairfaxva.gov*. | | | | |

**SEND THE COMPLETED FORM TO:**

City of Fairfax Fire Department | 4081 University Drive | Fairfax, Virginia 22030

Email: EMSBilling@fairfaxva.gov