



Request and Authorization for Disclosure of Health Information Form

City of Miramar Fire Rescue Department

14801 SW 27th St.
Miramar, FL 33027
(954) 602-4832
(954) 602-3981

<http://www.ci.miramar.fl.us/fire/>

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a patient has the right to access, inspect and copy their Protected Health Information (PHI) maintained by Miramar Fire-Rescue. Additionally, your rights allow you to request a copy, request to amend and/or request restriction of the use of any disclosure of your PHI.

This is an authorization requesting the City of Miramar Fire-Rescue Department to release medical reports and/or information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or by state law protecting the privacy of health information.

I, _____, hereby authorize the use and disclosure of the individually identifiable health information to be furnished to the requesting party below.

REQUESTING PARTY'S INFORMATION				
Name _____	Date of Request _____			
Address _____				
Phone Number _____	Apt./Suite # _____	City _____	State _____	Zip Code _____
PATIENT INFORMATION				
Name on Report _____				
Patient Date of Birth _____		Patient SSN _____		
Location of Incident _____		Date of Incident _____		
Time of Incident _____		Incident Number (if known) _____		

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

x _____
Signature of Patient or Personal Representative

Relationship to Patient _____

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____,
by _____.

Personally Known _____ or Produced Identification _____ Type of Identification Produced _____

(NOTARY SEAL)

Notary Public