



**CITY OF HOUSTON FIRE DEPARTMENT – EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR
RELEASE OF PROCTED HEALTH INFORMATION**

Read the instruction on page 3 carefully before completing this form

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I. PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY#:	DATE OF BIRTH:	

SECTION II. VOLUNTARY AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, voluntarily authorize the City of Houston, its agents, servants, employees, officials, and _____, Patient, Legal Guardian, or Authorized Representative Attorneys to release the following Emergency Medical Service records (i.e., documents, audio and video recording, etc.), maintained by the City of Houston, for the above-referenced patient for medical services provided on _____ to person listed in Section IV of this form. Date of Service

SECTION III. DESCRIPTION OF INFORMATION AUTHORIZED FOR RELEASE (See Instructions on Page 3 to complete this section)

- Entire Emergency Medical Services Record
- Only information related to (specify) _____
- Only the period of events from _____ to _____
- Other (specify) _____

If you would like any of the following sensitive information, disclosed, check the applicable box (es) below:

- Alcohol/Drug Abuse Treatment/Referral
- Sexually Transmitted Diseases
- HIV/AIDS-related Treatment
- Mental Health (other than Psychotherapy Notes)

SECTION IV. NAME AND ADDRESS OF PERSON OR ORGANIZATION TO RECEIVE PATIENT'S HEALTH INFORMATION

PLEASE PRINT

NAME: _____
ADDRESS: _____

SECTION V. PURPOSE FOR RELEASE (See instruction on Page 3 to complete this section)

Please provide the purpose for the use or disclosure:

SECTION VI. EXPIRATION DATE

Please provide a date or event upon which you wish this authorization to expire _____

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed.

**INSTRUCTIONS FOR COMPLETING
THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

1. Print legibly in all fields using blue ink.
2. **Section I**, print name, address, social security number, and date of birth of the patient.
3. **Section II**, print the name of the patient or authorized person. Then fill in the date of service.
4. **Section III**, check the appropriate box as applicable.
 - a. **Entire Emergency Medical Services Record** - the complete record except for sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS- related treatment, and mental health other than psychotherapy notes.)
 - b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.
 - c. **Only the period of events from** – specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002
 - d. **Other (specify)** – e. g., billing, employee health.
 - e. **IN ORDER TO RELEASE SENSITIVE INFORMATION INCLUDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES AND MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES); YOU MUST CHECK THE APPROPRIATE BOX.**
5. **Section IV**, print the name and address of the person to whom your health information should be released.
6. **Section V**, state the reason for release of the medical information, e.g., litigation, disability claim, continuing medical care, etc.

If this release is for litigation purposes, please include the case name, cause number, county or district, and court number.
7. **Section VI**, if a different *expiration* date is desired, specify a new date.
8. **Section XI**, sign and date in the presence of a notary. An authorized representative must include a description of their authority, i.e. legal guardian, power of attorney, etc.
9. A copy of the completed form will be given to the patient.