TOWN OF WATERTOWN FIRE DEPARTMENT

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") VOLUNTARY AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I _____ ("Patient") hereby authorize the Watertown Fire Department to use or disclose the health information set forth herein in Section 3 for the purposes set forth in Section 4. I understand that the information provided in Section 3, could be subject to re-disclosure by the Watertown Fire Department pursuant to this Authorization, and, if so, that said information may not be subject to federal or state law protecting its confidentiality.

1. Patient name:_____
Last name First name Middle Initial

2. Address:_____
Street City State and Zip Code

3. Information to be disclosed: _____ DRS (Complete Medical Records) _____ Invoice
_____ Patient Care Report (SARF) Other (please specify):_____

The following items which may appear in the records must be checked to be authorized for use and/or disclosure:

_____ HIV/AIDS related information and/or records
_____ Psychotherapy notes
_____ Other mental health information, communications and/or records
_____ Information acquired by any social worker consulting in their professional capacity
_____ Records that contain communication between myself and any psychotherapist, psychologist or allied mental health professional
_____ Records that contain any treatment notes, communications or other information regarding domestic violence or sexual assault
_____ Genetic testing information and/or records
_____ Contain any blood alcohol test results
_____ Relate to venereal disease
_____ Regard a child born out of wedlock
_____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.
Describe:_____

4. Information shall be disclosed to:_____
Name

Address:_____
Street City State and Zip Code

_____
Phone Fax

5. a. Treatment dates:_____to _____

b. Dispatch Location: _____

6. This Authorization may be revoked at any time, except to the extent that the Watertown Fire Department has already acted in reliance on the Authorization. To revoke this Authorization, the Patient or his/her legal representative must submit a written request to revoke to: Watertown Fire Department, EMS Coordinator, 99 Main St, Watertown, MA 02472

_____	_____
Signature of Individual	Date
_____	_____
Print name of Individual	Expiration Date (When this Authorization Expires; if No Date is Provided, Authorization Effective for One Year from Above Date)

A photocopy of this Authorization shall be the legal equivalent of the original.

513822/WATR/0013