



City of Poquoson Fire/Rescue

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

45 C.F.R. §164.506 and 508; HIPAA Authorization to Release Records; Code of Virginia §32.1-1-127.1:03, Health Records Privacy

The Poquoson Fire Department is hereby authorized to release confidential health records pertaining to Emergency Medical Services, care, and treatment of:

Patient's Name: _____

Name of Person requesting records (if different than Patient): _____

Address of Person requesting records: _____

Released To: _____
(Person, Agency, or Health Care Entity to whom disclosure is to be made)

Description of records to be disclosed or report number: _____

Purpose of Disclosure or at the request of the individual: _____

As the person signing this authorization, I understand that I am giving my permission to the Poquoson Fire Department for disclosure of confidential health records. I understand that the Poquoson Fire Department may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity. I understand that the Poquoson Fire Department may disclose confidential health records to specific entities (e.g. other treating health care providers) for specific purposes as permitted by federal and state law without my authorization, but may not release confidential health information to any entity or person not otherwise specified by federal and state law without my written authorization.

This authorization expires on (date) or in the event of: _____

Signature of Individual or Individual's Legal Representative if individual is unable to sign:

Date: _____

Relationship or Authority of Legal Representative (provide appropriate authorization (e.g. Durable General Power of Attorney, Order of Appointment as Guardian, or other written authorization): _____

Must provide at least one of the following:

- ☐ Driver's License (for self)
- ☐ Social Security Card (for self or minor)
- ☐ Birth Certificate (for minor)
- ☐ Insurance card (for minor)
- ☐ Immunization records (for minor)
- ☐ Subpoena
- ☐ Durable General Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Court Order of Appointment as Guardian
- ☐ Written authorization from patient
- ☐ Income tax form showing minor is a legal dependant (for minor)
- ☐ Written request from physician's office (for minor, records will be released directly to the physician's office)



City of Poquoson Fire/Rescue

POQUOSON FIRE DEPARTMENT ADMINISTRATION
830 Poquoson Avenue
Poquoson, Virginia 23662

By my signature below, I hereby acknowledge that on _____ I received a
copy of the FIRE/EMS Report Number _____.

Subject

Date

(If release is made to someone other than the subject patient of a report containing confidential personal health information, recipient must provide written authorization from patient for release of patient's confidential health records to the requesting individual, or a Durable General or other Power of Attorney specifying receipt of patient's health information, or an Order Appointing recipient as legal guardian of patient, prior to release of the report. Information may be released without written authorization to parent of a patient under the age of 18, or upon presentment of documentation that recipient is the legal guardian of a patient who is under the age of 18.)