STATEMENT OF EXPLANATION: Completion of this document is necessary to authorize North County Regional Fire Authority (the "RFA") to release your confidential and protected health information to another person or entity as required by federal and Washington State laws concerning the privacy of such information. **FAILURE TO PROVIDE THE REQUESTED INFORMATION MAY INVALIDATE THE AUTHORIZATION AND PREVENT THE RFA FROM ACTING IN RELIANCE ON THIS AUTHORIZATION. PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE ALONG WITH THIS FORM TO VERIFY IDENTITY.**

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip Code: _____

## ORGANIZATION PROVIDING INFORMATION

Name of Organization: North County Regional Fire Authority
Address: 8117 267th Street NW
Stanwood, WA 98292

## INFORMATION TO BE RELEASED

Incident Date: _____

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this authorization. I hereby authorize the disclosure of the following information pertaining to the incident date above to the recipient listed below:

- ☐ My entire MEDICAL record and any accompanying documents.
- ☐ My MEDICAL record limited to: _____.

## RECIPIENT RECEIVING INFORMATION

Name of Recipient: _____

Address: _____ City/State: _____ Zip Code: _____

Information used or disclosed pursuant to this authorization may be subject to further disclosure by recipients not covered by federal HIPAA regulations. Although disclosed information may no longer be subject to federal privacy protections, state law requires recipients to refrain from re-disclosing such information unless another written authorization is obtained or specifically required by law.

## EXPIRATION OF AUTHORIZATION

This authorization expires on: (date/event) _____
If no expiration is given, this authorization will expire ninety (90) days from the signature date below.

## REVOCATION OF AUTHORIZATION

I understand that I have the right to revoke this authorization at any time except to the extent that the RFA has already acted in reliance on this authorization. To revoke this authorization, I understand that I must do so by submitting a written request to:

North County Regional Fire Authority
Attn: Fire Chief
8117 267th Street NW
Stanwood, WA 98292
Office: 360-652-1246

The authorization will stop on the date the request to revoke authorization is received.

## PATIENT SIGNATURE

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that the RFA is prohibited from creating any conditions to treatment or payment based on me signing or not signing this authorization unless otherwise specified in this authorization. I acknowledge that I have read the provisions in this authorization, and I have received a copy. I understand and agree to the terms of this authorization.

Patient Signature: _____ Dated: _____

Representative Name: _____

Relation to Patient: _____ Translator Used? ☐ Yes ☐ No

_____

If you are NOT the patient but are acting on behalf of the patient, provide your name and relation to the patient. Patient representation is acceptable ONLY if the patient is unable to make the request when given the opportunity or the patient is a minor. A representative is defined as a parent of a minor, next-of-kin, power-of-attorney, or the one who is legally entitled to make medical decisions on behalf of the patient. Legal representatives must provide proof of power-of-attorney for the authorization to be valid. Parents of minors must provide proof that they have authority as the minor's representative, e.g., verification that the child is on the parent's health insurance plan as a dependent or presentation of the minor's birth certificate.

*Photocopies of this authorization will be considered as valid as the original.*