CONFIRE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS OR PERSONAL HEALTH INFORMATION

PLEASE READ DOCUMENT CAREFULLY

The undersigned authorizes CONFIRE to release Medical Reports for:

Patient's Name ______________________________

If not Patient: **Requestor's Name** ________________________________

Relationship to Patient ________________________________

Address __________________________________ **Phone No.** __________________________________

Incident Date _____________________ **Incident No.** __________________

Location ____

STATE PURPOSE FOR USE OR DISCLOSURE OF INFORMATION:

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If you are executing this authorization as a personal representative for the Patient, please describe your authority to act on behalf of the Patient:

____

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AUTHORITY DOCUMENTATION TYPE: ____

IDENTIFICATION TYPE:____

IDENTIFICATION EXPIRATION DATE:____

VERIFIED IDENTIFICATION BY:____

I understand that I have the right to revoke this authorization at any time by notifying the Director /Dispatch Manager in writing at CONFIRE, 1743 Miro Way, Rialto CA 92376. The authorization will stop on the date my request is received.
Initials: _____

I understand that if the recipient I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations; however, under California law, any recipient of my information may not further disclose my health information without a new written authorization unless otherwise permitted or required by law.
Initials: _____

I understand that I have a right to receive, and I will be provided with, a copy of this signed authorization.
Initials: _____

NOTES: ____

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This form may be signed by the patient; or authorized representative such as the patient's custodial parent or guardian if a minor; the legal representative of the patient; a deceased patient's beneficiary. Documentation will be required.

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.

Print Patient/Authorized Representative's Name: ______________________________

SIGNATURE: ______________________ DATE: ____________________