CITY OF KENT FIRE DEPARTMENT 

HIPAA RELEASE FORM

KENT, OH

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA RELEASE)

Signing this form, I acknowledge that I have voluntarily provided protected health information (PHI) about the undersigned to the City of Kent and the City of Kent Fire Department (KFD). I authorize KFD to use and or disclose to any emergency responder or contracted KFD coordinator with a need to know any and/or all such PHI about the undersigned.

In the event of an emergency involving the undersigned, this authorization permits KFD and agencies involved for the purposes of treatment or health care operations, to use and/or disclose to any emergency responder any and/or all PHI which has been voluntarily provided to KFD and/or agencies involved about the undersigned. Such emergency providers may include any hospital or healthcare provider requiring access to the PHI as part of the physician patient relationship.

Per my request, the PHI will only be used or disclosed to assist KFD and agencies involved in providing treatment, care, and services to the undersigned. In the event of an emergency, KFD can release my PHI as part of the physician patient relationship. Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected from disclosure by federal or state law.

This authorization will expire in 12 months from the date of my signature or upon my written revocation of this authorization.

KFD and agencies involved will receive no payment or other compensation from a third party in exchange for using or disclosing the PHI.

I agree to the disclosure of my PHI to agencies involved, including but not limited to for the purposes of receiving additional resources related to my health conditions.

I understand that I do not have to sign this authorization in order to receive treatment from any emergency provider. I have the right to refuse this authorization. I have the right to revoke this authorization in writing to KFD. My written revocation must be submitted the KFD office at

Kent Community Paramedicine Program

320 S. Depeyster St.

Kent, OH 44240-7912

Kent Fire Department HIPAA Release Form

Kent, Ohio

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA RELEASE)

Signed by:

Print Patient's Name

Date:

Signature of Patient, Parent, or Legal Guardian, if applicable Relationship to Patient

Print name of Parent or Legal Guardian, if applicable

Email address:

Home address:

Phone:

This authorization must be returned to:

Kent Community Paramedicine Program

C/O Sara Slanina

320 S. Depeyster St.

Kent, OH 44240-7912

330-676-7393

No PHI will in any way be accepted, used, released, an/or disclosed until an original signed copy of this form is received and logged by CCP coordinator or his/her designee.