Mountain View Fire Department

Authorization for Release of Medical Records

STATEMENT OF EXPLANATION
Completion of this document is necessary is to authorize the Mountain View Fire Department (MVFD) to release your confidential and protected health information to another person or entity as required by federal and California state laws concerning the privacy of such information. **FAILURE TO PROVIDE THE REQUESTED INFORMATION MAY INVALIDATE THE AUTHURIZATION AND PREVENT THE MOUNTAIN VIEW FIRE DEPARTMENT FROM ACTING IN RELIANCE ON THE AUTHURIZATION**

PATIENT INFORMATION		
Last Name:	**First Name:**	**Date of Birth:**
Address:		
City:	**State:**	**Zip code**

ORGANIZATION PROVIDING INFORMATION
Mountain View Fire Department – EMS Division, Custodian of Records **1000 Villa Street** **Mountain View, CA 94041**

INFORMATION TO BE RELEASED
Incident Date:
Incident Location (Address)
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 and information above: □ My entire Medical Record and any accompanying documents □ My MEDICAL Record limited to: ______________________________
PROTECTED CLASS INFORMATION Special approval, as required by law, is needed before the protected classes of information listed below can be released. These types of information may or may not be contained in your records. **To approve the release of your entire medical record, you must initial in all spaces below**
_____ Mental Health Treatment   _____ Substance Abuse Treatment _____ HIV / AIDS Test / Treatment   _____ Developmental Disabilities _____ Sexually Transmitted Disease Treatment

ORGANIZATION RECEIVING INFORMATION		
Name of Organization:	**Name of Requestor:**	
Address:	**Phone:**	
City:	**State:**	**Zip Code:**
Information used or disclosed pursuant to this authorization may be subject to further disclosure by recipients not covered by federal HIPPA 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.		

DESCRIPTION OF PURPOSE

The purpose of this authorization is for:

☐ Preparing the litigation of a claim on behalf of the above patient, pursuant to California Evidence Code §1158

☐ Other: ____

Each purpose listed above must be consistent with the actual use. Supporting documentation may be submitted with authorization to substantiate purpose of use and disclosure.

EXPIRATION OF AUTHORIZATION

This authorization expires on: (date / event) ____

If no expiration given, this authorization will expire 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 Mountain View Fire Department 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:

Mountain View Fire Department – EMS Division, Custodian of Records
1000 Villa Street
Mountain View, CA 94041

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

REVOCATION OF AUTHORIZATION

I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that the Mountain View Fire Department is prohibited from cre4ating any conditions to treatment based on me signing or not signing 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:	**Date:**
Representative Name:	**Relationship to Patient:**

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. A representative is defined as next-of-kin, power of attorney for health care, or the one who is legally entitled to make medical decisions on behalf of the patient. Legal representative must provide proof of medical or health care power of attorney for authorization to be valid.