Request and Authorization for Disclosure of Health Information Form

City of Marco Island Fire Rescue Department
50 Bald Eagle Dr.
Marco Island, FL 34145
(239) 389-5040
(239) 393-0099—Fax
http://www.cityofmarcoisland.com/index.aspx?page=140

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a patient has the right to access, inspect and copy their Protected Health Information (PHI) maintained by City of Marco Island Fire-Rescue. Additionally, your rights allow you to request a copy, request to amend and/or request restriction of the use of any disclosure of your PHI.

This is an authorization requesting the City of Marco Island Fire-Rescue Department to release medical reports and/or information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or by state law protecting the privacy of health information.

I, _____, hereby authorize the use and disclosure of the individually identifiable health information to be furnished to the requesting party below.

REQUESTING PARTY INFORMATION

Name _____ Date of Request _____

Mailing Address _____
Apt./Suite # City State Zip Code

Phone Number _____

PATIENT INFORMATION

Name on Report _____

Patient Date of Birth _____ Patient SSN _____

Location of Incident _____ Date of Incident _____

Type of Incident _____ Incident Number (if known) _____

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

x _____
Signature of Patient or Personal Representative

Relationship to Patient _____

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20___,
by _____
.
Personally Known ☐ or Produced Identification ☐ Type of Identification Produced_____

(NOTARY SEAL)

_____
Notary Public