

**BENBROOK FIRE DEPARTMENT EMS**  
**Authorization to Use or Disclose Protected Health Information**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Previous Name: \_\_\_\_\_

**I. My Authorization**

**I authorize Benbrook Fire Department to use or disclose the following health care information (check all that apply):**

- All health care information in my medical record  
 Health care information in my medical record relating to the following treatment or condition:  
\_\_\_\_\_  
 Health care information in my medical record for the date(s): \_\_\_\_\_  
 Other (e.g., X-rays, bills), specify date(s): \_\_\_\_\_

**I authorize Benbrook Fire Department to use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS Virus)                       Sexually transmitted diseases  
 Psychiatric disorders/mental health     Drug and/or alcohol use

**Benbrook Fire Department may disclose this health care information to:**

Name (or title) and organization or class of persons: \_\_\_\_\_  
Address (optional): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

**For the following reason(s) (check all that apply):**

- At my request                               Other (Specify) \_\_\_\_\_

**My authorization ends:**

- On (Date): \_\_\_\_\_                       When the following occurs: \_\_\_\_\_  
 In 90 days from the date signed

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study OR
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization at any time in writing. If I do, it would not affect any actions already taken by Benbrook Fire Department based upon this authorization. I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form (a form is available from Benbrook Fire Department), or
- Write a letter to Benbrook Fire Department.

**Once health care information is disclosed, I understand that the person or organization that receives it may re-disclose it and State or Federal Privacy laws may no longer protect it.**

\_\_\_\_\_  
Patient or legally authorized signature                                      Date                                      Time (Central Standard)

\_\_\_\_\_  
Printed name if signed on behalf of the patient                                      Relationship (parent, legal guardian, executor, etc.)