City of Dallas
Dallas Fire-Rescue

Authorization to Use/Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of SSN
Address		Telephone #

I hereby authorize the City of Dallas Fire-Rescue Department (DFR) to use or disclose my protected health information (PHI). Specifically, I authorize the use or disclosure of the below selected records:
(check all that apply)

☐ EMS (Ambulance) Medical Record ☐ EMS Billing Records / Itemized Statement

☐ Mobile Community Health Program Records ☐ Other_____

I understand that the information in my records may include information related to sexually transmitted diseases, acquired immunodeficiency disease (AIDS), or human immunodeficiency virus (HIV). It may also include information (other than psychotherapy notes) about behavioral or mental health services or treatment for alcoholism or drug abuse. I specifically authorize the release of this information. ******* _____ _____ **(initial here)*********

Yes or No

RELEASE MY RECORDS TO: (Please provide the name and address of person/organization to which to disclosure is to be made)

_____

_____

Phone #_____ Fax# _____

DATES OF SERVICE to be released: _____

must be completed

Reason for the release of records: ☐ Medical Care ☐ Insurance ☐ Legal ☐ Patient Request

☐ Billing/Collections/Claims ☐ Other, please specify_____

Provide my medical records by way of: please check one ☐ Paper ☐ Fax

This authorization is valid 30 days from the date it is signed unless it is revoked or a different date is provided here _____.

I understand that I may revoke this authorization at any time, except to the extent that the City of Dallas Fire-Rescue Department has already relied on the authorization. To revoke this authorization, I understand that I must do so by written request to the Privacy Officer, 1500 Marilla Street, 1B South, Dallas, Texas 75201. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law. DFR may not condition treatment, payment, enrollment or eligibility for benefits on my agreement or refusal to sign this authorization.

_____ _____

Date **Signature of Patient/Legal Representative**

If Patient Has a Legal Representative, complete the following:

_____ _____

Printed Name Relationship to Patient

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative. Proof of legal authority is required for legal representatives.

Submit completed forms to:

City of Dallas Fire-Rescue Department
EMS Division, Attn: Release of Information
1551 Baylor Street, Suite 300
Dallas, TX 75226
Phone: (214) 670-4311 Fax: (214) 670-5100