PATIENT AUTHORIZATION

To Permit Use and Disclosure of Health Information
By The City of Clayton, Missouri Fire Department

Re: _____ _____ ____/____/_____
Patient Name **Social Security Number** **Date of Birth**

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I authorize the City of Clayton Fire Department to use or disclose to _____

_____
Person or class of persons to whom use or disclosure would be made

the following protected health information: _____
Identify the information in a specific and meaningful fashion

_____

_____

The purpose of the use or disclosure is: _____
Describe each purpose of the requested use or disclosure

_____

_____

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The revocation must by submitted on the Revocation of Patient Authorization form, which is available from the Privacy Officer, Jeff Tobin, 314-290-8485. A revocation will not be effective to the extent that the City of Clayton Fire Department has already taken action in reliance on this Authorization.

I understand that I may refuse to sign this Authorization. I also understand that the City of Clayton Fire Department cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon _____
Date or event that relates to the patient or the purpose of the use or disclosure.

If the City of Clayton Fire Department is requesting this Authorization, you will receive a copy.

<OVER>

I have read and understand the information in this authorization form.

Signature of Patient:	
Please print name:	Date:

— OR —

Signature of Authorized Representative:	
Please print name:	Date:
Please explain Representative's authority to act on behalf of the Patient: _____ _____ If Representative's authority to act on behalf of the Patient is based on a written document, please attach a copy of such written document to this Authorization.	

State of _____)
) SS
County of _____)

On this _____ day of _____, 20___, before me personally appeared _____, to me known to be the person described in and who signed this Patient Authorization, by reviewing his/her driver's license and witnessing his/her execution hereof, and who acknowledged that he/she signed it voluntarily as his/her free act and deed, with full authority to obtain the requested information under federal and state law.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year above written.

My Commission Expires: _____
Notary Public