



KING COUNTY FIRE PROTECTION DISTRICT NO. 27

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

- checkbox All Health Information in my medical record;
checkbox Health Information in my medical record relating to the following treatment or condition:
checkbox Health Information in my medical record for the date(s):
checkbox Other (e.g., X rays, bills), specify date(s):

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

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

checkbox You may disclose this Health Information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- checkbox at my request
checkbox other (specify) _____

Authorization Expiration: (This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)

- checkbox in 90 days from the date signed checkbox on (date):
checkbox when the following event occurs: (no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
• Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)