Anchorage Fire Department

Authorization to Disclose Protected Health Information

To request release of medical information, please complete and sign this form, and return it to:

Anchorage Fire Department
Attention: EMS Records Custodian
100 E. 4th Ave
Anchorage, AK 99501

*You may submit this completed form via fax to: 907-267-4984

For help completing this form or questions, call AFD Medical Records Custodian at 907-267-5076.

PATIENT INFORMATION			
Last Name	First Name	Middle Name	Date of Birth
Street Address	City	State	Zip Code
Phone:	Email:		

By signing this Authorization, I hereby direct the disclosure by Anchorage Fire Department of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient (include date of service, if applicable):

_____

This information may be disclosed by Anchorage Fire Department to the following party (or parties):

_____

I understand that I have the right to revoke this Authorization at any time, except to the extent that Anchorage Fire Department has already acted in reliance to the Authorization. To revoke this Authorization, I understand that I must do so by written request to Anchorage Fire Department's HIPAA Compliance Officer: Battalion Chief Tyra, 100 East 4th Ave, Anchorage, AK 99501. Phone #: (907) 267-4973.

I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law. I understand that my written authorization is not required by Anchorage Fire Department to use my protected health information for treatment, payment and healthcare operations. I understand that I have the right to inspect and copy the information that is to be disclosed as part of this Authorization. The disclosure of the requested information will not result remuneration to Anchorage Fire Department from a third party.

The purpose of this Authorization for release of information is:

_____

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms. This authorization will expire **90 days** from the date signed.

Signature: _____ Date: _____

Printed Name

PERSONAL REPRESENTATIVE INFORMATION (If signer is different from patient, Anchorage Fire Department may require documentation of the personal representative's authority)		
Last Name	First Name	Complete Address:
Phone:	Relationship to Patient:	Description of the authority of personal representative:

NOTARY BLOCK: (*Please have this Notary Block completed for any Authorization Forms that are faxed or mailed in.)

SUBSCRIBED AND SWORN before me this _____day of _____ 20_____.

Notary Public in and for Alaska: _____

My Commission Expires: _____

For Internal Use: RMS # _____
DOS: _____
Date Mailed/Faxed or Picked Up: _____