



**Lake Havasu City Fire Department**  
**Fire Prevention Bureau**  
2330 McCulloch Blvd. N.  
Lake Havasu City, AZ 86403  
Phone: (928) 453-3313 Fax: (928) 453-3312

## Authorization for Release of Medical Information

Completion of this document authorizes the Lake Havasu City Fire Department to disclose and release individually identifiable health information as set forth below, consistent with Arizona Revised Statutes § 12-2291, 22-2292, 22-2293, 22-2294 and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

### USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information specifically identified herein regarding or related to:

**Patient Name** \_\_\_\_\_

**Incident Date** \_\_\_\_\_ **Incident Number** \_\_\_\_\_

**Incident Location** \_\_\_\_\_

I specifically authorize the release of medical records or information, if any, related to the diagnosis, treatment, and prognosis regarding any (initial next to each):

\_\_\_\_\_ Mental condition and/or treatment including psychotherapy notes; or

\_\_\_\_\_ Drug or alcohol abuse and/or treatment; or

\_\_\_\_\_ HIV or AIDS or AIDS related complex condition and/or treatment.

I authorize the following individual or entity to receive the disclosure of the medical report authorized herein: \_\_\_\_\_

The purpose of the authorized disclosure is<sup>1</sup> : \_\_\_\_\_

### EXPIRATION

This authorization shall expire and no longer be valid as of the following date or event<sup>2</sup> :

The following date: \_\_\_\_\_

The following event: \_\_\_\_\_

<sup>1</sup> The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

<sup>2</sup> If authorization is for use of disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.



**Lake Havasu City Fire Department**  
**Fire Prevention Bureau**  
2330 McCulloch Blvd. N.  
Lake Havasu City, AZ 86403  
Phone: (928) 453-3313 Fax: (928) 453-3312

**NOTICE OF RIGHTS AND OTHER INFORMATION**

**I understand the following:**

1. I may refuse to sign this Authorization
2. This Authorization may be revoked in writing at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: Lake Havasu City Fire Department, 2330 McCulloch Blvd. North, Lake Havasu City, Arizona 86403.
3. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
4. I have a right to receive a copy of this Authorization<sup>3</sup>.
5. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.
6. The information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, Arizona law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
7. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
8. This information will not be used for any marketing purposes whatsoever.

**SIGNATURE**

I, the undersigned, hereby authorize the Lake Havasu City Fire Department to release to the above, all medical reports relating to the pre-hospital care received. In furtherance of this authorization, I hereby waive all provisions of law and privileges of confidentiality relating to the disclosures hereby authorized.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Print Name

If signed by the patient's legal Representative, describe your authority to sign on behalf of the individual:

\_\_\_\_\_

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ )

SUBSCRIBED AND SWORN before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC SIGNATURE

<sup>3</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).