UCONN
UNIVERSITY OF CONNECTICUT

Division of University Safety
Fire Department

Authorization to Obtain and/or Disclose Health Information Form

1.) I hereby authorize the UCONN Fire Department to disclose and/or obtain my individually identifiable health information as described here to the person/organization named below. I understand that this authorization is voluntary and that it ***may include information relating to AIDS, HIV infection, behavioral health services / psychiatric care, treatment for alcohol and/or drug abuse***.

PATIENT'S NAME:			DATE OF BIRTH	
ADDRESS:			EMAIL:	
CI TY:	STATE:	ZIP:	PHONE #:	FAX #:

2.) Date of Service: _____ **3.)** Town of Service:_____ **4.)** Address of Service: _____

5.) Information to be disclosed or to be obtained:

☐ Patient Care Report(s) ☐ Dispatch Records ☐ Verbal Discussion of Patient Care
☐ Billing Records ☐ Other (Please Specify)

_____

6.) Please ***DO NOT*** release the following information: _____

7.) I am requesting that this information be disclosed or obtained for the purpose of *(i.e. Legal reasons, continued care, insurance, another medical opinion, Worker's compensation, research, personal use, Social Security)*: _____

_____

8.) Name of the person(s) /organization(s) to whom the disclosure is to be made or to whom the information is to be released to. If the disclosure is made to or released to more than one person/organization *for the same purpose,* more than one entry may be made below.

PERSON/ORGANIZATION #1 - NAME			**PHONE #**
ADDRESS			**FAX #**
CITY	**STATE**	**ZIP**	**EMAIL**

PERSON/ORGANIZATION #2 - NAME			**PHONE #**
ADDRESS			**FAX #**
CITY	**STATE**	**ZIP**	**EMAIL**

8.) Method to disclose or obtain information (Check all that apply):

☐ Facsimile to:	☐ Person/Organization #1	☐ Person/Organization #2
☐ US Mail to:	☐ Person/Organization #1	☐ Person/Organization #2
☐ Email to:	☐ Person/Organization #1	☐ Person/Organization #2

☐ To be picked up by (Name and relationship to patient of individual authorized to pick up record(s) being released from the facility): _____

9.) I understand this authorization may be revoked **in writing to the Chief of Department** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here. **DATE OF EXPIRATION**:_____

10.) I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what Connecticut State law authorizes.

11.) UCONN Fire Department, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

12.) In cases where UCONN Fire Department is requested by a third party to create health information solely for the purpose of sharing that information with the party that requested it, I understand that I must sign this authorization.

13.) ***Notice to Recipients:*** *As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:*

- *With written authorization from the patient or his or her legal representative*
- *As required or authorized by state and / or federal law; or*
- *If urgently needed for the patient's continued care.*

If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

14.) **Notice to Individual Requesting the Disclosure:**

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

Printed Name of Patient: _____

Signature of Patient or Legal Representative:_____Date:_____

Printed name of Legal Representative *:_____ Relationship to patient:_____
(* A copy of the personal representative's legal authority to act on behalf of the patient must be attached.)

Signature of Individual Picking up Record:_____Relationship to patient:_____

For Department Use Only

Date	
Check identification	
Records needed by:	
Charges:	
Copy of Authorization was provided to patient	

Processed by (UCONN Fire Representative):_____ Date:_____

AAG Approval:_____ Date:_____