



**AUTHORIZATION FOR RELEASE OF
PATIENT CARE REPORT OR NON-TRANSPORT PCR**

For the Use and Disclosure of Protected Health Information

PLEASE PRINT

Patient Information:

Name

Address **Apt. No.**

City **State** **Zip**

Date of Birth **Date of Treatment**

Location of Incident **Hospital Transported To**

Ambulance Number/Engine Number

By signing this Authorization Form, I understand that I am giving my authorization to the City of Chicago Fire Department to use and/or disclose my protected health information (PHI). **I specifically authorize the use and disclosure of PHI pertaining to a Patient Care Report or Non-Transport PCR to the following:**

Name/Organization

Address **Apt. No.**

City **State** **Zip**

Telephone Number

I specifically authorize the use and disclosure of the following:

- 9 Drug Treatment/Abuse
- 9 Alcohol Treatment/Abuse
- 9 Domestic Violence
- 9 Sickle Cell Anemia
- 9 Mental Health/Psychiatric
- 9 HIV/AIDS
- 9 Sexually Transmitted Diseases

I specifically authorize this use and disclosure for the following purpose: _____
_____.

This authorization shall expire on the 180th day after the signing or as specified _____
_____.

I may revoke this authorization at any time by notifying the City of Chicago in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed by the City of Chicago before the City received the written notice of revocation.

I understand that a potential exists that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary, and I may refuse to sign this Authorization form.

I understand that the City of Chicago's health care component may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the treatment is research-related.

I understand that I have the right to be provided with a copy of this signed authorization form.

Signature of patient or personal representative

Relationship to patient (if applicable)

Printed name of patient

Printed name of personal representative (if applicable)

Date

Subscribe and Sworn

This _____ **day, of**
_____, **20**_____

Notary Seal