King County Fire District #2
900 SW 146th Street
Burien, WA 98166
P: (206) 242-2040 | F: (206) 433-6042

Specific Protected Health Information

Authorization to Use and Disclose

Date_____

By signing this Authorization, I hereby authorize and direct the use or disclosure by King County Fire District 2 of certain medical information (PHI) pertaining to my health, my healthcare, or information regarding me.

This Authorization concerns the following medical information about me:
Response Date:_____ **Response Location:**_____
***Patient Name:**_____

This information may be used or disclosed by King County Fire District 2 and its business associates and may be disclosed to:

_____
List name or specific identification of the person (s) or class of persons to whom the requested use/disclosure may be made

I understand that I have the right to revoke this Authorization at any time except to the extent that the Fire District has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the District Privacy Officer ***[Charles Chen, Finance Manager 900 SW 146th, Burien, WA 98166, (206) 242-2040].***

I understand that information used or 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 to use my protected health information for treatment, payment/billing purpose, and healthcare operations. I understand that I have the right to inspect and copy my PHI. The Authorization is being requested for the following purpose(s):

_____
_____
_____

The use or disclosure of the requested information, will ☐ or will not ☐ result in direct or indirect remuneration to the Fire District from a third party.

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.

***Patient Signature**_____ **Drivers License #** _____
Date_____ **Contact Phone # :**_____

Description of the authority of personal representative, if applicable, a copy of power of attorney for deceased patient_____
This authorization expires on: _____ (date or event)

For Internal Office Use Only

Date received:_____ (__) Request Approved (__) Request Denied

Explanation of Denial: _____

_____

Reviewed/Approved by:_____ **Release Date:**_____

Incident #:_____

If applicable: # of Pages_____ Amount Charged_____ Fee Paid By: (__) Cash (__)Check Receipt#_____