AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

The Pinellas County Safety & Emergency Services d.b.a. Sunstar EMS is requesting your client's or other individual's authorization to use or disclose their health information. This form must be completed and signed by the patient/personal representative in order for Sunstar to release the patient's records.

1. Description of health information being requested, with date(s) of service (mm/dd/yy):_____

__ Patient care report(s) __ ECG __ Invoice __ Sunstar Membership Fee

2. Entity authorized to use, or make the requested use or disclosure:

PINELLAS COUNTY SAFETY & EMERGENCY SERVICES DBA SUNSTAR

3. Attorney's office, law firm, or other person authorized to receive the health information:

_____

4. Purpose of the requested use or disclosure: _____

5. Expiration Date or event (include only one or the other):_____

6. Right to Revoke: I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to:

Pinellas County Safety & Emergency Services d.b.a. Sunstar: 12490 Ulmerton Road, Largo, FL 33774

7. Exceptions to Right of Revocation: I understand that my written revocation will not affect the ability of EMS to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, EMS cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

8. Prohibitions on Conditions: I understand that my ability to receive treatment is not conditioned on my signing this Authorization.

9. This Authorization is binding: The statements made in this Authorization are binding, controlling and I understand that they take precedence over statements made in EMS's Notice of Privacy Practices.

10. Authorization Approval:

I hereby authorize the use or disclosure of the health information described in this Authorization. I understand that my health information may not be protected by federal privacy laws and may be subject to re-disclosure by the recipient person or organization, unless such re-disclosure is otherwise prohibited by State law.

Signature: _____

Print Name: _____

Date of Birth: _____Last 4# of SSN: _____

Date: _____

Basis for legal authority to sign this Authorization by a personal representative:

_____

(Parent, Guardian, POA with Designation of Health Care Surrogacy, Estate Personal Representative)

ATTACHMENT A

Implementation Notes and General Authorization[1]

1. **Implementation Note for Paragraph 1 of the attached Authorization:** Insert a specific and meaningful description that identifies the health information to be used or disclosed. For example, "the records associated with the emergency transport that occurred on July 4, 2003."[2] Only that specific health information may then be used or disclosed. The covered entity is obligated to clarify any ambiguity of what health information may be used or disclosed before using or disclosing the individual's health information.[3]

2. **Implementation Note for Paragraph 2 of the attached Authorization:** Insert with sufficient specificity the name or other specific identification of the person(s), or class of persons, authorized to use or disclose the health information. For example, "all physicians" would not constitute the appropriate reasonable specificity required.[4] If the health information is to be used only by the covered entity, then the answer in paragraph 2 will be the same as the answer in paragraph 3.

3. **Implementation Note for Paragraph 3 of the attached Authorization:** Insert with sufficient specificity the name or other specific identification of the person(s), or class of persons, who may receive and use or disclose the health information. For example, "all government agencies" would not constitute the appropriate reasonable specificity required.[5] If the health information is to be used only by the covered entity, then the answer in paragraph 3 will be the same as the answer in paragraph 2.

4. When individuals initiate an authorization for their own purposes, the purpose may be described as being at the request of the individual.

5. **Implementation Note for Paragraph 5 of the attached Authorization:** Insert an expiration date or description of an expiration event that relates to the individual or to the purpose of the use or disclosure. The expiration date or event is subject to otherwise applicable and more stringent state law.[6] For example, applicable state law may permit authorizations to remain in effect for a shorter period and would take precedence over a stated longer expiration date or event.[7] Indeterminate expiration dates are prohibited.[8]

6. **Implementation Note for Paragraph 10 of the attached Authorization:** The authorizations must be in writing and signed.[9] Verification of the identities of individuals signing authorization forms and notarizations are not required.[10] Authorizations should be dated on the day they are signed.[11]

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[1] 45 C.F.R. § 164.508(c).

[2] 45 C.F.R., Parts 160 and 164, p. 82517.

[3] Ibid.

[4] Ibid.

[5] 45 C.F.R., Parts 160 and 164, p. 82518.

[6] Ibid.

[7] Ibid.

[8] 45 C.F.R., Parts 160 and 164, p. 82660.

[9] Ibid.

[10] Ibid.

[11] 45 C.F.R., Parts 160 and 164, p. 82661.