Grant County Fire Protection District No. 3
Authorization to Use or Disclose Health Information

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

☐ All Health Information in my medical record;
☐ Health Information in my medical record relating to the following treatment or condition: _____
☐ Health Information in my medical record for the date(s): _____
☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose this Health Information to:

Name (or title) and organization: _____
Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

☐ at my request ☐ other (specify) _____

Authorization Expiration: *(This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)*

☐ in 90 days from the date signed ☐ on (date): _____
☐ when the following event occurs: _____
(no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
- Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I declare under penalty of perjury of the Laws of the State of Washington that I am the Patient identified above.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)