ORRVILLE FIRE DEPARTMENT

Authorization to Use and Disclose
Specific Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by Orrville Fire Department of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

_____

_____

This information may be used or disclosed by Orrville Fire Department and may be disclosed to:

_____

_____

(LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU MAY MAKE THE REQUESTED USE/DISCLOSURE)

I understand that I have the right to revoke this Authorization at any time except to the extent that Orrville Fire Department has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Orrville Fire Department Privacy Officer as follows:

> Chief Robert C. Ballentine
> Orrville Fire Department
> 223 North Vine Street
> PO Box 129
> Orrville, OH 44667
> Phone: 330-684-5050

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 for Orrville Fire Department to use my protected health information for treatment, payment and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Orrville Fire Department for the following purpose(s):

_____

_____

_____

The use or disclosure of the requested information will___/will not___ result in direct or indirect remuneration to Orrville Fire Department 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.

_____[Name]   _____[Date]

_____[Description of the authority of personal representative, if applicable]

This authorization expires on _____ [Date or Event].