**AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable state law, this authorization form must be completed in its entirety to authorize the Liberty Township Fire Department to disclose protected health information.

DATE SUBMITTED: _____

Patient Name: _____

Incident Date: _____

Incident Location: _____

Incident Number: _____

I, my personal representative, or person authorized to act on my behalf regarding medical records, authorize the Liberty Township Fire Department to use or disclose the patient care report(s) corresponding to the incident(s) above to the following individual or organization:

Name: _____

_____

Address: _____

Disclosure Purpose: _____

Expiration Date or
Event: _____

You retain the right to revoke this Authorization in writing at any time prior to the disclosure by contacting the Liberty Township Fire Department, EMS Records Office. Liberty Township does not condition treatment upon the signing of this Authorization. The information disclosed by this authorization may be redisclosed by the recipient and is no longer protected by the HIPAA or applicable state law. This authorization is valid for one year from the date submitted to Liberty Township Fire Department.

_____   _____
Signature   Date

_____
Printed Name

IDENTITY VERIFICATION

State of _____

County of _____, SS:

Having first been duly cautioned and sworn, I hereby do swear that I am the patient stated above, a personal representative of the patient as defined by Ohio Revised Code 3701.74, or have been authorized in writing by the patient within one year of the date of this authorization to act on the patient's behalf with regard to medical records.

_____
Relationship to Patient (if not the patient)

_____   _____
Signature   Printed Name

On this _____ day of _____, 20 ___, the above named individual appeared before me and swore that the forgoing is true to the best of his or her knowledge and belief.

_____
Notary Public

My Commission Expires: _____

Identity Verification (*Division Use Only*)	
Form of Identification:	
Relationship to Patient (if not the patient):	
Released By (Signature)	Released By (Printed Name)

Revised: January 13, 2025