Authorization for Release of
Protected Health Information (PHI)

Date ________________

Patient Name: ______________________________ Date of Birth: ______________________

Address: ____

Requesting Party (if other than Patient): ____

Relationship to Patient: ____

Address: ____

Phone Number:__________________ Fax Number (if report is to be faxed):_______________

Incident Address/Location: ____

I acknowledge that a copy of the Thornton Fire Department's Privacy Notice Form has been provided to me, and that I have had the opportunity to address any questions I have with a Privacy Officer about the privacy practices of the Thornton Fire Department.

Signature of Patient/Legal Guardian: ____

____ To Access existing PHI for the time frame of ____________________ (Date of Service)

I would also like to request that the following parties receive access to the necessary PHI in order to carry out my requested action (please initial below):

____ To facilitate pursuit of a filed complaint. I authorize the following individuals to receive access to the minimum necessary information specific to the filed complaint dated _____________:

Initials	Individual's Name	Purpose for Involvement
____	____________________________	____________________________________
____	____________________________	____________________________________
____	____________________________	____________________________________
____	____________________________	____________________________________

____To Amend, Restrict or Account for PHI, all parties involved in treatment, payment or healthcare operations of this patient specific to the filed request dated________________.

DEPARTMENT USE ONLY

Request Received by: ____

Identity Confirmed by: Driver's License Passport Birth Certificate POA Notarized Release

Other Government issued Photo ID______________ Other_____________________________

Identity of Legal Guardianship Confirmed by: Legal Power of Attorney Medical Power of Attorney

Advanced Directive_______________ Other____________________________________

Documents provided:______________ Date Processed:_________via: FAX Mail In person

Signature of Privacy Officer: ____