City and County of Denver
Denver Fire Department

AUTHORIZATION TO USE OR DISCLOSE CONFIDENTIAL INFORMATION

This form gives permission to the Denver Fire Department to use or disclose confidential information of one of its patient's to a third party.
Email completed form to : DFDreportrequest@denvergov.org

ALL sections of this form must be completed for it to be considered valid. This form is 2 pages.

Date: ______________________

INDIVIDUAL WHOSE INFORMATION IS TO BE DISCLOSED:

Name: ____________________________________ Date of Birth: ______________________

DENVER FIRE DEPARTMENT IS AUTHORIZED TO DISCLOSE THE CONFIDENTIAL INFORMATION OF THE INDIVIDUAL LISTED ABOVE TO THE FOLLOWING PERSON AND/OR ORGANIZATION:

Name: _____________________________________ Organization: _______________________________

Phone Number: ______________________________ Email Address: ______________________________

Mailing address including zip code: ____

____

Information to be disclosed (check all that apply):

______ Information related to patient's acute medical condition, history, and/or treatment rendered by the DFD

______ Other (Please be specific): ____

____

PURPOSE OR NEED FOR INFORMATION BEING REQUESTED: (Please be specific)

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EXPIRATION OF AUTHORIZATION:

This authorization expires on the following event, condition, or exact date (if not revoked before), which I agree is no longer than reasonably necessary to serve the purpose for which is given: ____________________________________

____

STATEMENT OF UNDERSTANDING:

I understand that the Denver Fire Department reserves the right to withhold disclosure of the above information if the disclosure is reviewed by and deemed not appropriate by the DFD Privacy Officer, the Denver City Attorney's Office, or both.

I understand the DFD has no control over information once it has been disclosed to a third party, and cannot protect the information after it is released to any third parties based on this Authorization.

I understand that I may revoke this Authorization at any time by writing the DFD. Such revocation will be effective when the DFD receives it.

I understand that my records are protected and that any information released pursuant to this consent remains subject to the restrictions stated in Title 42 of the Code of Federal Regulations, Part 2, governing the protection of confidential client information and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164. Any further disclosures or any disclosures used for any purpose other than indicated above, without my written consent, will be in violation of my confidential rights.

I understand that my health care treatment or payment, or my enrollment or eligibility for health care benefits cannot be conditioned in any way upon my executing this Authorization.

I certify that this Authorization has been signed voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

____ YES, I WOULD LIKE A COPY OF THIS SIGNED FORM.

Patient signature:____**Date:** _________________________

Parent or Legal Guardian may sign on behalf of minor child client.

Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult client – documentation providing legal authority must be provided.

Relationship: (if not signed by client) ____

INFORMATION PROVIDED BY:

Date provided: ____________________________ Phone Number of DFD Employee:______________________________

Name of DFD Employee providing Information: _______________________________________

Organization:____________Denver Fire Department____

Address, City, State, Zip: 745 W Colfax Ave Denver, CO 80204_____________________________________

IMPORTANT: If this form is provided by email or fax, please include a copy of identification for the person who has signed above. If this form is provided in person, the person who signed above must show proof of identity and person receiving records must show proof of identity. There is no exception to this requirement. Without proper ID, records will not be released.