CITY OF Grand Junction COLORADO
FIRE

PATIENT/GUARDIAN CONSENT TO RELEASE EMS RECORDS

Patient's Consent for Disclosure of Protected Health Information

Patient Information		
Name:		Date of Birth:
Street Address:		Phone:
City:	State:	Zip Code:
Treating Facility Name and Address: Grand Junction Fire Dept, 330 S 6th St, Grand Junction, CO 81501		EMS Incident #:(s) and Date(s)

Parent or Guardian Information (for Minor Patients)		
Name:		Date of Birth:
Street Address:		Phone:
City:	State:	Zip Code:

I authorize the Grand Junction Fire Department to release the Emergency Medical Services (EMS) records from of the Patient named above. I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Name of Individual or Organization _____ Address _____

Name of Individual or Organization _____ Address _____

I understand this authorization will expire, without my express revocation, one year from the date of signing or, if I am a minor, on the date of my eighteenth (18th) birthday. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization and that a copy or facsimile of this authorization with my signature may be used with the same effectiveness as the original document.

I understand that authorization for the disclosure of health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on obtaining an individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

I waive the doctor-patient privilege provided by 13-90-107 CRS.

Signature of Patient or Parent/Guardian for Minor _____ Date _____

Signature Authorized Personal Representative _____ Date _____

Print Name and Relationship of Personal Representative _____

Signature of Witness _____ Date _____

Signature of Witness _____ Date _____

This authorization reflects the requirements of HIPAA, 45 CFR § 164.508