

The Village of Woodmere Department of Public Safety Division of Emergency Medical Service / Fire Medical Records Request and Authorization to Use and Disclose Specific Protected Health Information (PHI) Form

Instructions: This is an interactive form with the exception of the areas that require a signature and the Notary Section at the end. This form is to be filled out completely and no blank spaces. This form can be filled in online and then printed or printed then filled in. In order to process a request, the completed and notarized form along with a \$7.00 fee (check or money order) per patient/per date must be submitted to:

The Village of Woodmere Fire Department Department of Public Safety Division of Emergency Medical Service / Fire 27899 Chagrin Boulevard Woodmere Village, Ohio 44122

Checks and Money Orders can be made payable to: The Village of Woodmere Fire Department

ALL INFORMATION/BLANK SPACES MUST BE FILLED IN FOR VALID AUTHORIZATION (USE N/A IF APPROPRIATE)

Request	or Information	
Name of Requestor:		
Relationship to Patient:		
Firm Name:(If requestor is an Attorney, otherwise use "N		
Requestor's Address:		
City:	State:	Zip Code:
Requestor's Phone Number:		
Requestor's Signature:		Date:
Authorization By Patient or Parent/Le	egal Guardian To D	Disclose PHI To Requestor
By signing this Authorization, I,		, hereby authorize the
disclosure to the above Requestor by The Vill	lage of Woodme	ere of certain medical information
pertaining to the health, health care of:		

Patient's Name:		
Address:		
City:	State:	Zip Code:
Date of Service:		
Location of Service:		
Relationship to Patient:		
This Authorization is for the release of the forpatient (check all that apply) O Patient Care Run Report O Billing Statement O Diagnostic Procedures O Other:	ollowing medica	l information about the above name
(N	Must be specific)	
This information may be used by The Villag	ge of Woodmere	and may be disclosed to:
(List names or identification of person(s) or class of pe	ersons to whom the descri	ibed medical information is to be disclosed)
This information is being used or disclosed	for the following	Purpose(s):
(State specific purpose	e(s) or "By the request of	the patient")
This Authorization shall be in forced and eff	fect until (specify	date or event):

I understand that I have the right to revoke this Authorization at any time, except to the extent that The Village of Woodmere has already acted in reliance on the Authorization prior to the above expiration date or time, I understand that I must do so by written request to The Village of Woodmere EMS Contact/Privacy Officer (Lieutenant S. Latif Ibn Ali I., Woodmere Fire, 27899 Chagrin Boulevard, Woodmere, Ohio 44122, phone number 216-292-4103).

I understand that information used or disclosed pursuant to this Authorization may be subjected to re-disclosure by the recipient and no longer subjected to privacy protections provided by law. I understand that this information may be hand-delivered, mailed, faxed or verbalized, dependent upon the circumstances of the request.

I understand that my written authorization is not required for The Village of Woodmere 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.

I acknowledge that I have read the provisions in this Authorization and that I have the right to refuse to sign this authorization. I understand and agree to its terms.

IMPORTANT

The remainder of this form MUST be signed by the Patient, or, if a minor, his/her authorized parent or legal guardian, in the presence of a Notary Public.

Print name	Print Title:		
(Patient or Parent / Legal Guardian			
Signature	Date:		
State of:			
) SS:		Affix Seal	
County of :			
Subscribed to and sworn before me this	day of	, 20	
by	·		
Notary	Public		
Signatu	re:		
My Cor	mmission Expires On:		