DURHAM COUNTY EMERGENCY MEDICAL SERVICES

Authorization to Use and Disclose Protected Health Information

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Date of Service: _____

SSN: _____

This document authorizes and instructs Durham County Emergency Medical Services (DCEMS) to furnish to:

_____

_____

(Insert name and address of person or entity to receive the protected health information)

the following specific medical record(s) constituting protected health information ("PHI" as that term is defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA - P.L. 104 -191]) and its implementing regulations, as amended, and applicable State law, including G.S. §143-518:

☐ Patient Care Reports ☐ History ☐ Physical ☐ Billing Records

☐ Substance Abuse information ☐ HIV/AIDs status ☐ Mental Health/Psychotherapy notes

The requested protected health information is disclosed for the following purposes:

- ☐ Medical
- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☐ Other (please specify):_____

This Authorization will expire on the following date or event:_____.

I understand that if I fail to specify an expiration date or event, this Authorization is valid for one year from the date of signature.

I also understand and acknowledge that if I specify the Authorization expires based on an event that does not involve Durham County Government (DCG), DCG will not have knowledge of that event's occurrence and so I must take action to inform them it has occurred. DCG shall not be held liable for any disclosures made pursuant to this authorization, prior to receipt of notification that the event has occurred.

I understand that this Authorization is in effect from the date of my signature.

I understand that I may revoke this Authorization at any time, except to the extent that action has been taken in reliance on it or during a contestability period under applicable law. See revocation section at the bottom. I understand that all revocations of authorizations must be submitted in writing, in accordance with HIPAA. Written revocations of authorizations must be submitted to:

Durham County EMS
Records Custodian
201 E. Main Street, Ste. 660
Durham, NC 27701
Email: EMSrecords@dconc.gov

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations 42 C.F.R. part 2, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

By affixing my signature below, I acknowledge that I release Durham County, DCEMS, their elected officials, agents, and employees from any and all liability whatsoever in connection with this Authorization to release medical records or information. A photocopy of this Authorization may be used in place of the original.

The use and disclosure of the requested information will NOT result in any direct or indirect renumeration to Durham County Emergency Medical Services from a third party.

I verify that my execution of this Authorization is truly voluntary. I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, enrollment in a health plan, or my eligibility for benefits from Durham County Emergency Medical Services. I understand that I have a right to receive a copy of this signed Authorization.

_____ _____
Signature Date

_____
Printed Name

I am (select one below):
☐ the patient
☐ the parent/guardian of the patient who is under 18 years of age
☐ a court appointed or other authorized personal representative of the patient
(If other than the patient, please explain your relationship/authority below and attach a copy of the relevant documents establishing your relationship/authority):
_____
_____

REVOCATION SECTION

I do hereby request that this Authorization to disclose health information of _____
Name of Patient
signed by _____
Name of Person Who Signed Authorization

on _____ be rescinded, effective _____.
Enter Date of Signature *Date*

I understand that any action taken on this authorization prior to the rescinded date, or date of receipt of this Revocation by Durham County at the address specified in the Authorization, whichever is later, is legal and binding.

_____ _____
Patient Signature *Date*

_____ _____
Signature of Personal Representative / (Relationship or Authority) *Date*