



Reeves County Emergency Services District No. 1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Original Date: 02/23/2024

Revision Date: 03/07/2024

Patient's/Subject's Full Name

Date of Accident or Incident for Which Records are Requested

Address

Patient's/Subject's Date of Birth

City, State Zip Code

Patient's/Subject's Telephone Number

I hereby authorize use or disclosure of Protected Health Information about me as described below:

- 1. Reeves County Emergency Services District No. 1 is authorized to use or disclose information about me/my child.
- 2. The following specific person (or class of persons) may receive the protected health information of me/my child.

PHI Recipient Name

Address

City, State, Zip Code

- 3. The specific information that may be disclosed is (please include date of accident or incident):

UNLESS YOU SIGN HERE, No information about Drug, Alcohol, or Substance Abuse; HIV/AIDS; Genetic Information or Mental Health will be disclosed:

YES, DISCLOSE THIS INFORMATION: _____

NO, DO NOT DISCLOSE THIS INFORMATION: _____

- 4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and it may then no longer be protected by Federal or State privacy regulations.
- 5. I may revoke this authorization by notifying Reeves County ESD No. 1 in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

FEE FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient's records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice if, in the opinion of the District, the copies are voluminous.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual

(The person about whom the information relates)

Date of Birth

Date of Signature

OR, if applicable –

Signature of guardian or personal representative or executor/estate administrator.

Date of Signature

Description of Authority to Act

– For Official Use Only –

Date Received _____

File _____

Processed _____
