



SOUTHWEST TELLER COUNTY

EMERGENCY MEDICAL SERVICES

147 E. Bennett Ave. ♦ P.O. Box 826 ♦ Cripple Creek, CO 80813
(719) 689-0240 ♦ FAX (719) 689-0292

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize use or disclosure of all protected health information about me as described below (check all that apply):

- All medical records for the period of _____ to _____.
- All billing records including all statements, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand the following: See CFR §164.508(c)(2)(i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative

Date

(See 45CFR § 164.508(c)(1)(vi))

Name and Relationship of Legally Authorized Representative to Patient

(See 45CFR §164.508(c)(1)(iv))

Witness Signature

Date

If requesting the information to be sent to the patient, please fill out the requested method:

- **Mailed to:** (please include address)
- **Secured Email:** (please include Email address)
- **Picked up:** from the Cripple Creek Fire station, 147 E. Bennett Ave., Cripple Creek, CO 80813

If requesting information to be sent to a third party:

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

Please submit completed form and copy of a valid ID in 1 of the following ways.

- Email to Director@swtcems.org with the subject as "Records Request"
- Fax to (719)689-0292
- Mail to Southwest Teller County EMS, P.O. Box 826, Cripple Creek, CO 80813
- Or drop it off at Cripple Creek Fire station, 147 E. Bennett Ave., Cripple Creek, CO 80813