North Lincoln Fire & Rescue District #1
PO Box 200, Lincoln City, OR 97367
541-996-2233
541-996-5344 (Fax)
Website: www.nlfr.org

HIPAA Authorization Form

I, _____, hereby authorize the disclosure of my protected health information as described below; OR

I, _____, as the parent or legal guardian of the minor child _____, hereby authorize the disclosure of their protected health information as described below; OR

I, _____, having been granted medical power of attorney or other written permission from _____, hereby authorize the disclosure of their protected health information as described below:

1. **AUTHORIZED AGENCY TO DISCLOSE PROTECTED HEALTH INFORMATION**

   North Lincoln Fire & Rescue District #1 is authorized to disclose the following protected health information to _____

2. **DESCRIPTION OF INFORMATION TO BE DISCLOSED**

   The health information that maybe disclosed is:

   Patient care records of treatment provided by members of North Lincoln Fire & Rescue District #1 on this date: _____

3. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____ and expires in thirty (30) days.

4. ACKNOWLEGEMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: _____ Date: _____

STATE OF _____

COUNTY OF _____

Signed (or attested) before me on _____, 20____

by _____

_____
Notary Public – State of Oregon