Authorization For Use And Disclosure of Health Information

I, _____, give permission to **Pinellas County's Regional 9-1-1 Division**, located in the Regional 9-1-1 Center to use and/or disclose the following protected health information to:

(Persons/classes of persons/organizations authorized to receive the health information)

Name: _____ **Relationship to patient:** _____

Address : _____ **Phone #:** _____

Re: **Name of Patient:** _____

Specific description(s) of the protected health information (check or circle all that apply)**:**

___911 Call(s) **___ F.D. Radio Traffic** **___CAD Notes**

Description of purpose for requested use or disclosure: _____

Expiration Date/Event: I would like this authorization to expire on: **(date) ____/____/___; or (event)** _____

_____

Right to Revoke: I understand that I have the right to revoke this Authorization in writing at any time, except to the extent the information has been released in reliance upon this authorization. (Public Safety Services cannot rescind disclosures it has already made.) To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to Pinellas County Public Safety Services, 9-1-1 Systems at 400 S Ft. Harrison Avenue, Ste 140, Clearwater, FL, 33756.

Prohibitions on Conditions: I understand that my ability to receive 911 services is not conditioned on my signing this Authorization.

This Authorization is binding: The statements made in this Authorization are binding, controlling and I understand that they take precedence over statements made in Public Safety Services' Notice of Privacy practices.

Authorization Approval:

I hereby authorize the use or disclosure of the health information described in this Authorization. I understand that my health information may not be protected by federal privacy laws and may be subject to redisclosure by the recipient person or organization, unless such redisclosure is otherwise prohibited by State law.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

(Note: If the patient's personal representative signs the authorization, the authorization also *must* include a description of that person's authority to act for the patient.)

>> **Mailing Address**:	>> **Email, Phone, Fax**:
Regional 9-1-1 **Attn: 9-1-1 Records Custodian** **10750 Ulmerton Rd, Bldg 1, Ste 343** **Largo, FL 33778**	**EMAIL:** 911records@pinellascounty.org **PHONE #:** (727) 464-3841 **FAX #:** (727) 464-3265