Norwich Fire Department
Authorization for Use or Disclosure of Health Information

Patients and law offices must use this form to request EMS reports. Patients must fill out the form, and send it to Norwich Fire Department. The Fire Department will only accept original, signed forms. Faxes will not be accepted. Reports will normally be sent within two weeks of receipt of the request.

Mail or deliver to: Norwich Fire Department, 300 Main Street, P.O. Box 376, Norwich, VT 05055-0376

I hereby authorize the use or disclosure of my Health Information as described below. I understand that this authorization is voluntary.

Individual's Name: ____

Individual's SSN:____

Person/Entity authorized to provide the information: _____________________________________

Person/Entity authorized to receive the information: _____________________________________

Specific description of the information including (if practicable) the date(s) of services related to the information: ____

The purpose of the use or disclosure is:
❑ At the request of the Individual (Check box if applicable)
❑ Other: (Please list purpose for each use or disclosure) __________________________________

I understand that if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by privacy regulations.

I understand that I may see and copy the information described in this Authorization Form, and that I will receive a copy of this Authorization Form after I sign it.

I understand that this Authorization expires on ______________ or the date the following event occurs: ____________________________ (describe event or write 'not applicable').

I understand that I may revoke this Authorization at any time by written notice to the Norwich Fire Department at the above address.

I understand that if I revoke this authorization, the revocation will not have any effect on actions taken by the Norwich Fire Department before receiving my revocation.

____
Signature of Individual or Legal Representative

____
Date

____
Relationship if Legal Representative
(Except for Legal Representatives acting in capacity as a parent to the patient, a copy of documentation giving the Legal Representative the authority to sign this Authorization must be attached.)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION