EMS Division
Detroit Fire Department
Authorization to Use and Disclose Specific Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by EMS Division of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

_____

[PRINT FULL NAME, DATE(S) OF SERVICE AND DESCRIPTION OF INFORMATION REQUESTED]

This information may be disclosed by EMS Division to and used by:

MINUTE MAN SERVICES, INC. 3905 ROCHESTER RD. - ROYAL OAK MI 48073

[LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU WANT EMS TO MAKE THE REQUESTED USE/DISCLOSURE]

I understand that I have the right to revoke this Authorization at any time except to the extent that EMS Division has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to: EMS Division Privacy Officer, 250 W. Larned, Detroit, Michigan 48226. Telephone: (313) 596-5180.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for EMS Division to use my protected health information for treatment, payment and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested from the EMS Division for the following purpose(s):

( ) at my request
(X) other purpose. Please state: LEGAL REVIEW

I understand that the EMS Division will not condition its treatment on whether I sign this authorization. I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms and acknowledge that I have received a copy of this authorization.

_____ _____

[Signature] **[Date]**

_____

[Print Name. If applicable, description of the legal authority*]

***If patient is a minor, describe the legal relationship of the minor with the person signing the authorization. If personal representative or legal guardian, please attach a copy of the Letters of Authority.**

This authorization expires on initial fulfillment of this request; unless another date or event is specifically stated.
(date or event) _____

Subscribed and sworn to before me on
this _____day of _____, 20____

_____

Notary Public
County of _____
My commission expires on:

An incomplete form can not be processed and will be returned in its entirety to the sender.