Unified Fire Authority
Patient Authorization to Access Protected Health Information - Behavioral Health

Patient Last Name	First Name	Middle Initial
Current Address	City	State
Date of Birth　　Last Four Of SS#	Email	Contact Phone

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have a right to obtain a copy of that information electronically. In addition, you may request that we transmit a copy of your PHI directly to another person and we will honor that request when required by law to do so. Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.

Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as a power of attorney) or other information necessary to verify that the requestor has the right to access PHI. In limited circumstances, we may deny you access to your PHI and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

If you want us to send the PHI to a third party, please fill out the information below:

Designated Party:____

Street: ____

City: ________________________ State: _______ Zip Code:__________________

Phone ____________________________

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

____ ________________________

Signature of Patient Or Legal Representative　　Date

__________________________ ____

Print Name　　If Legal Representative, relationship to patient

This authorization expires on_________(date or event). If left blank it expires in 180 days.