Special Needs Program
Washington Township, Dublin Ohio

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA RELEASE)

By signing this Authorization for Use and Disclosure of Protected Health Information (Authorization), I acknowledge that I have voluntarily provided or may voluntarily provide protected health information (PHI) about me, my child under eighteen 18 years of age, or my legal ward to the Washington Township Special Needs Program (WTSNP), operated by the Washington Township Fire Department. I authorize WTSNP to use and/or disclose to any emergency responder with a need to know all PHI about me, my child under eighteen 18 years of age, or my legal ward, including mental health records, prescription drug information, drug/alcohol/substance abuse records, genetic information, and/or HIV/AIDS test results/treatment

Per my request, the PHI will be used or disclosed only for the purpose of assisting emergency responders in providing any medical treatment or lack thereof to me, my child under eighteen 18 years of age, or my legal ward.

This authorization will expire on my written revocation of this Authorization.

WTSNP will not receive payment or other remuneration from a third party in exchange for using and/or disclosing the PHI.

I understand that I do not have to sign this Authorization in order to receive treatment from any emergency responder. In fact, I have the right to refuse this Authorization. When my information is used or disclosed pursuant to this Authorization, the person or entity that receives the information may not be health care provider or health plan covered by the federal privacy regulations, and therefore, it may be re-disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this Authorization in writing except to the extent that WTSNP has acted in reliance upon this Authorization. My written revocation must be submitted to the privacy officer at:

Washington Township Special Needs Program
C/o WTFD EMS Manager
6200 Eiterman Rd
Dublin, OH 43016

By signing below, I understand and acknowledge the following : 1.) I have read and understand this Authorization and 2.) If I have any questions bout disclosure of my protected health information, I may contact the Washington Township Fire Department EMS Manager.

Signed By: _____ _____
Signature of Patient, Parent, or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Patient, Parent, or Legal Guardian if applicable

_____
Address — Phone Number

This Authorization must be returned to:

Washington Township Special Needs Program
C/o WTFD EMS Manager
6200 Eiterman Rd
Dublin, OH 43016

No PHI will be released and/or disclosed until an original signed copy of this form is received and logged-in by WTSNP coordinator or his designee.