Patient Authorization to Use and Disclose Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by Canandaigua Emergency Squad of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

To use my likeness in a photograph in any and all of its publications, including but not limited to all Canandaigua Emergency Squad printed and digital publications. I understand and agree that any photograph using my likeness will become property of Canandaigua Emergency Squad and will not be returned. I acknowledge that since my participation with Canandaigua Emergency Squad is voluntary, I will receive no financial compensation.

This information may be used or disclosed by Canandaigua emergency Squad and may be disclosed to:

The general public without restriction.

I understand that I have the right to revoke this Authorization at any time, except to the extent that Canandaigua Emergency Squad has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Canandaigua Emergency Squad's HIPAA Compliance Officer:

Chief Matthew Sproul
233 N. Pearl Street
Canandaigua, NY 14424

585-394-5860
msproul@canandaiguaes.org

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 Canandaigua Emergency Squad to use my protected health information for treatment, payment and healthcare 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 by Canandaigua Emergency Squad for the following purpose(s):

Edit, alter, copy, exhibit, publish or distribute for marketing, fund raising, or other purposes of publicizing Canandaigua Emergency Squad, its services, or programs.

The use or disclosure of the requested information will not result in direct or indirect remuneration to Canandaigua Emergency Squad from a third party, but may result in financial donations being given to Canandaigua Emergency Squad. I hereby hold harmless and forever discharge Canandaigua Emergency Squad from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on behalf or on behalf of my estate or may have by reason of 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.

This authorization expires on: _____ (Write "No Expiration" for permanent usage)

Signature: _____ ***Date:*** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Description of the authority of personal representative:

_____

_____

Street Address: _____

City: _____State: _____ Zip Code: _____