CITY OF VIRGINIA BEACH
Emergency Medical Services

Emergency Medical Services
Custodian of Medical Records

The Bruce W. Edwards EMS Headquarters and Training Center
4160 Virginia Beach Boulevard | Virginia Beach, VA 23452

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Your medical information, including your name, date of birth, treatment dates, is considered protected health information and may not be disclosed, except under certain circumstances (see Notice of Privacy Practices on the City of Virginia Beach Department of Emergency Medical Services (VBEMS) web site for more information). This form allows you to authorize VBEMS to disclose your personal health information to those individuals (such as your spouse or relatives) or entities you specify.

NAME: _____ DATE OF BIRTH: _____
Last Name, First Name, MI

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ LEGAL REPRESENTATIVE

I voluntarily authorize the City of Virginia Beach Department of Emergency Medical Services ("VBEMS") to disclose my Protected Health Information as described in this authorization.

1. VBEMS Staff are authorized to release my protected health information to:
   - ☐ Specific person: _____
   - ☐ Relationship: _____
   - ☐ Specific organization:

     _____

     Please specify who, with the organization listed above, is covered by this authorization:
     - ☐ All persons with specific organization
     - ☐ Specific class of persons with organization(*Examples: Clinicians, Researchers, Etc.):*

     _____

2. VBEMS Staff are authorized to disclose the information for the purpose of the following:
   - ☐ At the request of the individual/persons/organization authorized in #1 above or
   - ☐ State specific purpose:

     _____

3. VBEMS Staff are authorized to release the information as indicated below (check all that apply) to the individual(s) and/or organization(s) listed above:
   - ☐ Patient medical records
   - ☐ Billing information
   - ☐ Authorization and appeals or
   - ☐ State specific description of information:

     _____

4. VBEMS Staff are authorized to release the information stated above in the following format:
   - __ Physical paper copy
   - Mail: please provide the address you'd like the report mailed to:

     _____

     _____

   - ☐ Electronic (encrypted email)
   - ☐ Electronic (non-encrypted email): note this is not recommended as it places your PHI at risk of being stolen.
   - ☐ Fax, please provide the fax number _____

5. VBEMS Staff are authorized to release the information stated above for the following dates from the date signed by the Member or Legal Representative on this form:
   - ☐ This one time only
   - ☐ Throughout current calendar year
   - ☐ 30 Days
   - __ _____ Days (specify)

_____

I understand that I have the right to revoke this voluntary authorization at any time by notifying in writing to:

City of Virginia Beach Department of Emergency Medical Services
Medical Records Division
4160 Virginia Beach Blvd.
Virginia Beach, VA 23452

I understand that the revocation is only effective after it is received and logged by EMS Staff.
I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by revocation.
I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.
I understand that I am entitled to receive a copy of this authorization

_____

_____ _____

Signature of Patient or Legal Representative: **Date**

_____ _____ _____

Signature of Witness **Date**

_____ _____

Name of Witness *(Please print first, middle and last name)* **Date**

If a Legal Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the basis of: