



Bennett Fire Protection District 7

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Date(s) of Service: _____

Patient Rights: As a patient, you have the right to access, inspect, and obtain a copy of your protected health information (PHI) as permitted by the Health Insurance Portability and Accountability Act (HIPAA). You may also request that we correct or amend information you believe is inaccurate or incomplete, request an accounting of certain disclosures, or ask that we limit how your PHI is used or shared. These rights are outlined in the District's *Notice of Privacy Practices*, which you may request at any time. The District will review and respond to all requests in accordance with applicable federal and state laws.

To better allow us to process your request, please indicate the type of request you are making on this form: (Check all that apply)

- Access to simply review my health information or billing information** maintained by Bennett-Watkins Fire Rescue
- Access to obtain copies of my health information** in paper or electronic form
- Access to review and potentially request amendment** of my health information
- Request for release to an insurance carrier or third-party administrator** for claims, appeals, or reimbursement purposes (requires signed authorization).
- Request for release of records for legal purposes**, such as for an attorney, court case, or subpoena (requires signed authorization and verification of legal authority).
- Request for records related to law enforcement or investigative review**, as permitted under HIPAA and applicable Colorado law.

Signature: _____ Request Date: _____

If other than patient, please state relationship _____

Please include a copy of your Driver's License when submitting a request. Thank you!