City of Wilmington Fire Department, NC

HIPAA AUTHORIZATION FORM

Patient's Full Name (Please Print Legibly)

Patient's Social Security Number

Address

Patient's Date of Birth

City, State, Zip Code

I hereby authorize **THE WILMINGTON FIRE DEPARTMENT** to use, disclose and/or release the above-named individual's protected health information as described below to the following:

1. The following person may receive protected health information about the above-named individual:

   Name (Please Print Legibly)

   Address

   City, State Zip Code

2. Please provide the completed Emergency Medical Services (EMS) report from (date)_____
3. Other _____
4. The purpose of the information: _____.

Signature of Patient or Legal Representative of Patient's Estate

Date

Signature of Person Picking Up Report

Date

Official Use Only		
Date Received	Processed By	Report #