FIRE RESCUE
ALBEMARLE COUNTY
460 Stagecoach Road, Suite F Charlottesville, VA 22902-6489
Voice: 434-296-5833 FAX: 434-972-4123
www.ACFireRescue.org

HIPAA RELEASE
and
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established regulations which require healthcare providers to ensure they are protecting the privacy and security of patients' medical information. This form is authorization to use or disclose protected information.

Patient Name:		**Date of Birth:**	
Social Security Number:		**Telephone:**	
Address:			
City:		**State:**	
ZIP Code:	**E-Mail Address:**		

Complete the following only if the person authorizing the use or disclosure is not the patient.

Name:		**Relationship:**	
Legal Authority:			
Verification of Identity:			
Verification of Authority:			

By signing this form, I authorize the University of Virginia Health System & UVA WorkMed to disclose to:

☒ Me, the individual patient or legal authority
☐ My primary care provider (PCP) [Check this box to have results sent directly to your PCP in addition to yourself.]

the following protected information:

☒ Annual physical exam results

My PCP information:

Provider Name:			
Firm/Organization:			
Address:			
City:		State:	
ZIP Code:		FAX:	
Telephone:			

I further authorize the release and disclosure of:

☒ Fit-for-duty status

to:

☒ Albemarle County Department of Fire Rescue
☒ Albemarle County Department of Human Resources

for the purposes of:

☒ Fulfilling employment requirements and occupational medical program requirements.

I further authorize the release and disclosure of:

☒ Non-identifiable raw data and medical component data points as listed in my Pre-Exam Instructions

to:

☒ Albemarle County Department of Fire Rescue

for the purposes of:

☒ Data collection, reporting, and research.

I understand that, by federal law, the University of Virginia Health System and UVA WorkMed may not use or disclose my health information, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release the University of Virginia Health System and UVA WorkMed and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This authorization automatically expires 365 days from the date of my annual physical exam.

I have read and understand the information in this Authorization.

Signature of Patient or Legal Authority: _____

Date: _____