AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

THIS SECTION TO BE FILLED OUT BY THE APPLICANT: (please print)

Patient Name: _____ Date of Birth: _____
Address: _____

_____

Phone: _____ Volunteer Station (Number): ____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The Medical Board of the Baltimore County Volunteer Firefighter's Association may receive disclosure of protected health information about me from the CRISP system which is the designated Health Information Exchange in Maryland and the District of Columbia. https://www.crisphealth.org/for-patients/

2. The specific information that should be disclosed includes:
   a. Any information relating to past or present prescriptions.
   b. Any information relating to past or present physical or mental health conditions.
   c. Any information relating to past or present provision of health care.

I understand that:

3. This authorization is voluntary.
4. The information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.
6. This authQrization is valid for one year from the date signed, OR unless an earlier date is specified here: _____ , OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: ----------
7. I may revoke this authorization by notifying the BCVFA Medical Board in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
8. My purpose/use of the information is for Physician Review of Medical Conditions to Determine Readiness for Duty as a Fire Fighter or Emergency Medical Services Responder.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING -

_____ _____
Signature of Individual Date of Individual's Signature
(The person about whom the information relates)