Coconut Creek Fire Rescue
Authorized Representative/ HIPAA Form

PLEASE PRINT CLEARLY

Instructions

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

1. Complete all sections of this form.
2. Securely email, mail, or fax completed form and supporting documentation to:
   Secure Email: CCFRadmin@coconutcreek.net
3. Address: 4701 Johnson Road Suite 8, Coconut Creek, Florida ,33073
   Phone: (954)973-6706
4. If you have any questions about completing this form, please contact Coconut Creek Fire Rescue Consumer Services at (954)973-6706.

This form is used to document the designation of an Authorized Representative for a patient. This form authorizes the release of medical information to the representative named below. This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a Power of Attorney or Living Will, please discuss this with your attorney. To remove an Authorized Representative, complete Steps 1, 3 and 4 on this Form. The Date of Revocation cannot be retroactive. If a retroactive date is indicated, the revocation will be administered effective as of the date this Form is received by us.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____/_____/_____	* Social Security number
* Contact phone number			* Employer	

Section 2 Authorized Representative Information

* Authorized representative name			* Date of birth _____/_____/_____
* Social Security number			* Phone number
* Permanent address	* City	* State	* Zip code

Section 3 Revocation of Authorized Representative (Complete only if removing an Authorized Representative)

I hereby revoke the appointee previously named Authorized Representative and have notified them of this change.

* Authorized Representative Name	* Date of Revocation

Section 4 Authorized Use, Expiration, Conditioning, and Disclosure

I understand that due to HIPAA and other privacy regulations, Coconut Creek Fire Rescue will not disclose my personal health information to other parties withoutmy written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my AuthorizedRepresentative is not a healthcare provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal health information, and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary. This authorization will expire twelve (12) months from the date on which it was signed unless revoked before expiration.

I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person named in Section 2 to remain my Authorized Representative, I must revoke this authorization in writing by completing Sections 1, 3 and 4 of this form thus giving notice of my decision to Coconut Creek Fire Rescue. I understand that my revocation of this authorization will not affect any action that has been taken, or any information that has already been released based upon this authorization before Coconut Creek Fire Rescue actually received my request to revoke it. I acknowledge that this form may be

* Consumer signature	* Date

electronically signed, and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.