



AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION

PATIENT INFORMATION (Please Print):

Last Name	First Name	M.I.	Date of Birth	
Address		City	State	Zip Code
Date of Treatment		Location of Incident		
Ambulance Number/Engine Number		Hospital Transported To		

I, _____, HEREBY AUTHORIZE the Chicago Fire Department
Full Name

TO DISCLOSE TO: Records Deposition Service / Jessica Gore

Person(s) to Whom CFD May Disclose

P.O Box 5054

Address	MI	48086-5054
Southfield		
City	State	Zip
(248) 357-3330		
Telephone Number	Fax Number	E: requests@recdep.com

THE INFORMATION INDICATED BELOW COVERING THE PERIOD OF _____

- ☐ Entire patient record
☐ Other: _____

I UNDERSTAND THAT IF I SO INDICATE BELOW, THE INFORMATION DISCLOSED MAY INCLUDE THE FOLLOWING:

- ☐ STD Test Results & Treatment
☐ Mental Health Treatment
☐ Alcohol Treatment
☐ HIV/AIDS Test Results & Treatment
☐ Drug Treatment & Evaluation
☐ Domestic Violence History

THE INFORMATION I HAVE INDICATED ABOVE WILL BE USED FOR THE FOLLOWING PURPOSE: _____

THIS AUTHORIZATION IS VALID UNTIL 1 YEAR FROM THE DATE OF SIGNATURE OR AS SPECIFIED HERE: _____

I UNDERSTAND THAT: I have the right to revoke this authorization at any time by giving written notice to the Chicago Fire Department at 3510 S. Michigan Ave., 2nd floor, Attn: CFD Records Division, Chicago IL 60653. Such revocation shall have no effect on uses or disclosures made prior to the revocation. The Chicago Fire Department may not condition treatment, payment, enrollment, or eligibility for benefits on this authorization or my refusal to sign this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

Date _____ Patient Signature _____

Date _____ Signature of Patient's Personal Representative _____ Personal Representative's Relationship to Patient (i.e., authority to act on patient's behalf)

Subscribe and Sworn
This _____ day, of _____, 20____

Notary Seal