Authorization to Use and Disclose Specific Protected Health Information (PHI) of a Deceased Person

Valley Regional Fire Authority
1101 D Street NE
Auburn, WA 98002
Office: (253) 288-5800
www.vrfa.org/records
HIPAA Compliant Records Request Portal

REQUIRED: **Please attach a copy of the government-issued photo ID** of the person whose signature appears on this document for the release of records

By signing this Authorization, I hereby authorize and direct the use or disclosure by Valley Regional Fire Authority (VRFA) of certain medical information (PHI) pertaining to the health care of a deceased person.

This Authorization concerns the following medical information about the following deceased person:

____ [Name of deceased] _____/_____/_____ [DOB]

This information may be used or disclosed by Valley Regional Fire Authority and its business associates and may be disclosed to:

____

I understand that I have the right to revoke this Authorization at any time, except to the extent that the VRFA has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Privacy Officer [Michelle Roy, Records Analyst, 1101 D Street NE, Auburn, WA, 98002, 253-288-5800].

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law. I understand that my written authorization is not required to use the aforementioned PHI for treatment, payment, and health care operations. I understand that I have the right to inspect and copy the PHI.

The Authorization is being requested for the following purpose:

____

____

The use or disclosure of the requested information will ___ / will not ___ result in direct or indirect remuneration to the VRFA from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms. I further certify that I am either the personal representative of the deceased person whose PHI I seek to be disclosed, or a person who would have been statutorily authorized to give informed consent to the health care of the deceased person, while that person was living, and therefore am authorized to give consent to the disclosure of the requested PHI pursuant to RCW 70.02.140 and/or RCW 7.70.065(1)(a).

_______________________________________ [Printed Name] ____/____/_______ [Date]

_______________________________________ [Signature]

I make this authorization as one or more of the types of persons statutorily authorized [under either RCW 70.02.140 or RCW 7.70.065(1)(a)] of the above-mentioned deceased person.

This authorization expires on: ____ [date or event].