



**ROBERTSON COUNTY EMERGENCY MEDICAL SERVICE
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
PERSONNEL INTERVIEW**

This form allows a patient (or the patient's personal representative) to authorize Robertson County Emergency Medical Service personnel to speak with a designated person, such as an attorney, about the patient's protected health information ("PHI") from a specific incident. This authorization covers **oral communications only**. It does not authorize the release of copies of records. To request copies of records, complete the "Patient Request for Access to Protected Health Information" form or submit a separate written authorization for release of records.

SECTION 1 — PATIENT INFORMATION:

PATIENT NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ EMAIL: _____

SECTION 2 — INCIDENT COVERED BY THIS AUTHORIZATION:

This authorization applies only to the single incident described below.

Date of Service: _____ CFS or OCA number (if known): _____

Incident location (if known): _____

Other identifying details: _____

SECTION 3 — WHO MAY DISCLOSE THE INFORMATION:

Robertson County Emergency Medical Service and its personnel who responded to, or were involved in, the incident described in Section 2 (for example, the EMS crew members and supervisors assigned to the call). If you wish to limit this authorization to specific personnel, list them below.

Specific personnel (optional): _____

SECTION 4 — WHO MAY RECEIVE THE INFORMATION:

LAW FIRM / ORGANIZATION: _____

ATTORNEY OR CONTACT NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ EMAIL: _____

____ Also includes paralegals, investigators, and staff employed by the law firm or organization named above and acting under the named attorney's direction.



SECTION 5 — DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

Oral communications (in person, by telephone, or by video conference) with the personnel described in Section 3 regarding their personal observations, assessment, treatment, and transport of the patient during the incident described in Section 2. Communications are limited to that incident.

Specially protected information. Personnel will not discuss the following types of information unless you initial them below:

- _____ (INITIAL) HIV/AIDS testing, status, or diagnosis
_____ (INITIAL) Mental or behavioral health information
_____ (INITIAL) Alcohol or drug use information

SECTION 6 — PURPOSE OF THE DISCLOSURE:

- _____ At the request of the patient
_____ Legal representation, claim, or litigation
Other (describe): _____

SECTION 7 — EXPIRATION:

This authorization expires on the date or event below, whichever occurs first. If neither is completed, this authorization expires one (1) year from the date it is signed.

Expiration date: _____ Or expiration event: _____

SECTION 8 — INTERVIEW CONDITIONS:

By signing, you and the recipient named in Section 4 acknowledge the following conditions:

1. This authorization **permits** Robertson County Emergency Medical Service personnel to speak with the recipient. It does not **require** Robertson County Emergency Medical Service or any staff member to participate in an interview. Robertson County Emergency Medical Service may approve, limit, or decline any interview request.
2. The recipient must submit interview requests in writing to the HIPAA Compliance Officer, identifying the personnel requested, all proposed attendees, and the general topics to be covered.
3. Robertson County Emergency Medical Service will schedule any approved interview during normal business hours, at a Robertson County Emergency Medical Service location, alternate site as approved, by an approved telephone or video platform.
4. The HIPAA Compliance Officer, a supervisor, and/or Robertson County Emergency Medical Service legal counsel may attend any interview.
5. Personnel will speak only to facts within their personal knowledge about the incident in Section 2. Personnel will not provide expert opinions.
6. If Robertson County Emergency Medical Service declines or limits an interview, the recipient may seek the information through formal legal process.



SECTION 9 — YOUR RIGHTS:

- **Right to revoke.** You may revoke this authorization at any time by giving written notice to the HIPAA Compliance Officer, Robertson County Emergency Medical Service. Revocation does not apply to information already disclosed in reliance on this authorization.
- **No conditioning.** Robertson County Emergency Medical Service will not condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.
- **Redisclosure.** Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
- **Copy.** You are entitled to a copy of this signed authorization.
- **Voluntary.** Signing this authorization is voluntary. You may refuse to sign it.

SECTION 10 — SIGNATURE:

I have read this authorization, and I understand and agree to its terms.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ DATE: _____

PRINTED NAME: _____

IF SIGNED BY A PERSONAL REPRESENTATIVE:

A copy of documentation establishing the representative's legal authority (for example, a guardianship order, medical power of attorney, or letters testamentary or of administration for a deceased patient) must be attached. **The patient's attorney may not sign on the patient's behalf** unless the attorney also holds legal authority under Texas law to act as the patient's personal representative (see Procedure 400.033).

REPRESENTATIVE NAME: _____

LEGAL AUTHORITY (GUARDIAN, MEDICAL POA, EXECUTOR, ETC.): _____

PHONE: _____ EMAIL: _____



OFFICE USE ONLY

Date Received: _____ Received Via (in person / mail / email / fax): _____

_____ All required authorization elements present (Sections 2, 3, 4, 5, 6, 7, 9, and 10 complete)

ID Verified Via: _____

Representative Authority Verified Via (if applicable): _____

Referred to RCEMS legal counsel (date): _____ Counsel: _____

Interview decision:

_____ Approved

_____ Approved with limits (describe below)

Limits: _____

_____ Declined

Interview Date / Time: _____ Location / Platform: _____

Personnel participating: _____

RCEMS attendees: _____

Copy of signed authorization provided to patient (date): _____

Approved by: _____

Coleman French, HIPAA Compliance Officer