TRUMBULL COUNTY SPECIAL NEEDS REGISTRY

OPERATED BY THE TRUMBULL COUNTY BOARD OF COMMISSIONERS
FRANK S. FUDA, PRESIDENT
MAURO CANTALAMESSA
DANIEL E. POLIVKA

TRUMBULL COUNTY 911 DISPATCH CENTER
911 HOWLAND WILSON RD. NE, WARREN, OH 44484

Trumbull County Special Needs Registry (TCSNR) TRUMBULL COUNTY, OHIO AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA RELEASE)

By signing this Authorization for Use and Disclosure of Protected Health Information (Authorization), I acknowledge that I have voluntarily provided or may voluntarily provide protected health information (PHI) about me, my child under eighteen (18) years of age, or my legal ward to the Trumbull County, Ohio Special Needs Registry (SNR), operated by the Trumbull County Board of Commissioners and administered by the Trumbull County 911 Dispatch Center. I authorize SNR to use and/or disclose to any emergency responder with a need to know any and/or all such PHI about me, my child under eighteen (18) years of age, or my legal ward.

In the event of an emergency involving me, my child under eighteen (18) years of age, or my legal ward, this Authorization permits SNR, for purposes of treatment or lack thereof, to use and/or disclose to any emergency provider any and/or all PHI which I have voluntarily provided to SNR or may voluntarily provide to SNR about me, my child under eighteen (18) years of age, or my legal ward. Such emergency providers include any hospital or healthcare provider requiring access to this PHI as part of the physician-patient relationship.

Per my request, the PHI will be used or disclosed only in the event of an emergency for the purpose of assisting emergency responders in providing any treatment or a lack thereof to me, my child under eighteen (18) years of age, or my legal ward. This purpose is provided so that I may make an informed decision whether to allow release of the PHI.

This authorization will expire on my written revocation of this Authorization. TCSNR will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I understand that I do not have to sign this Authorization in order to receive treatment from any emergency provider. In fact, I have the right to refuse to sign this Authorization. When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this Authorization in writing except to the extent that SNR has acted in reliance upon this Authorization.

My written revocation must be submitted to the privacy officer at:

Trumbull County Special Needs Registry
C/O Trumbull County 911 Dispatch Center
Attn: Mauro DiVieste, Special Needs Coordinator
911 Howland Wilson Rd. NE
Warren, Ohio 44484

Signed by:

_____ _____
Print Patient's Name Date

_____ _____
Signature of Patient, Parent, or Legal Guardian, if applicable Relationship to Patient

_____
Print Name of Patient, Parent, or Legal Guardian, if applicable

Email address: _____

Address: _____

Phone: _____

This Authorization must be returned to:

Trumbull County Special Needs Registry
C/O Trumbull County 911 Dispatch Center
Attn: Mauro DiVieste, Special Needs Coordinator
911 Howland Wilson Rd. NE
Warren, Ohio 44484
(330) 675-7966
erdivies@co.trumbull.oh.us

No PHI will in any way be accepted, used, released, and/or disclosed until an original signed copy of this form is received and logged-in by SNP coordinator or his designee.

Print Form