Travis County Emergency Services District No. 12

Human Resources Department
11200 Gregg Lane • PO Box 846
Manor, TX 78653
O: 512-272-4502 • F: 512-428-5114

APPLICATION FOR EMPLOYMENT

Important instructions for completing the application:

- Please TYPE or PRINT in BLACK INK. Applicant should retain a copy for your records.
- This application can be filled out electronically, save completed application as a unique file name and print.
- All initials and signatures must be in ink, no electronic signatures or initials will be accepted.
- Applications are accepted only for job titles for which recruitment is currently being conducted.
- All requested and required information must be completed on the application. Incomplete or illegible applications will not be processed.
- This application form and its attachments are official property of Travis County ESD No. 12 and will not be returned, reused or copied for you after being submitted. You should retain a copy of this application for future use or reference.
- Excessive or nonessential attachments will not be referred to the hiring department. Only information necessary to complete the application should be attached. Examples of work, awards, letters, etc., may be taken to the interview.
- If more space is needed to give full answers or explanations additional sheets referencing the item number, your name, social security number and job title applied for. Staple attachments to the application.
- Only United States citizens or aliens who are legally entitled to work in the United States are eligible for employment.
- Travis County ESD No. 12 affords equal employment opportunity to all individuals regardless of race, color, national origin, sex, religion, age, qualified disability status or veteran status.
- If you require an accommodation of have questions during the application/interview process, please call the Administrative Offices of Travis County ESD No. 12 at 512-272-4502.
- Reimbursement for travel expenditures during an interview process or drug screen is not available unless otherwise advised.
- Ensure you meet the minimum qualifications for each position.
- Applications are accepted Monday through Friday from 8:00 AM to 5:00 PM at the Administration Office or by mail.

  Applications may be mailed to: Travis County ESD No. 12 – PO Box 846 – Manor, TX 78653

  Applications may be dropped off at: 11200 Gregg Lane – Manor, TX 78653

  Emailed or Faxed applications will not be accepted.

Name: _____ Last 4 SSN: _____

Travis County Emergency Services District No. 12

Human Resources Department • (Physical) 11200 Gregg Lane • (Mailing) PO Box 846 Manor, TX 78653
O: 512-272-4502 • F: 512-428-5114

Applicant Checklist

Assemble your application packet in the following order and include this form with your submittal:

Initial beside each item included:

_____ COMPLETED APPLICATION
_____ DRIVING RECORD REPORT (Department of Public Safety Type 3A)
_____ CRIMINAL HISTORY REPORT (Department of Public Safety)
_____ COPY OF LIABILITY INSURANCE
_____ COPY OF DRIVER LICENSE (Must be physical address)
_____ COPY OF H.S. DIPLOMA OR EQUIVALENT
_____ COPY OF COLLEGE TRANSCRIPTS (Unofficial or Official)
_____ COPY OF ALL CERTIFICATIONS (Certifications must be valid and in date)
_____ SIGNED RELEASE OF PERSONAL INFORMATION
_____ AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FORM (HIPPA)

Applicant shall submit the above information in one of the following ways:

Mail your application and supporting documents, in a sealed envelope to:
Travis County ESD No. 12
Attn: Human Resources Department
P.O. Box 846
Manor, Texas 78653

Or

Drop off application and supporting documents in a sealed envelope to the Travis County ESD No. 12 Fire Department Main Station:
Travis County ESD No. 12
Attn: Human Resources Department
11200 Gregg Lane
Manor, TX 78653

Name: _____ Last 4 SSN: _____

Travis County ESD No. 12 – APPLICATION for MEMBERSHIP

Volunteer ☐ or PAID ☐ Position Applying For _____

Application Received:

APPLICANT ID#

Your interest in joining the fire department is appreciated. The public service nature of our operation requires that we carefully screen applicants. Your honest and careful completion of this application is required. Please fill in all the blanks and print all information.

NAME _____ **APPLICATION DATE** _____
LAST, FIRST MIDDLE (AS ON DRIVER LICENSE SUBMITTED)

ADDRESS _____ **CITY** _____ **ST** _____ **ZIP** _____

HOME PHONE _____ **WORK PHONE** _____ **CELL** _____

EMAIL ADDRESS (personal): _____ **SOCIAL SECURITY NO.** _____

DRIVER LICENSE NO. _____ **STATE** _____ **CLASS** _____ **RESTRICTIONS** _____
Must attach a copy of driver license and a copy of current personal automobile liability insurance.

ARE YOU EITHER A U.S. CITIZEN OR AN ALIEN AUTHORIZED TO WORK IN THE US? YES ☐ **NO** ☐
Proof of citizenship or work authorization will be required for employment.

HOW LONG HAVE YOU BEEN A RESIDENT OF THE STATE OF TEXAS? _____
If less than five (5) years, list all addresses of residency outside the state of Texas.

_____

_____

_____

NOTE – *If you have lived in the state of Texas for less than three (3) years and were previously a driver in another state, you will be required to obtain your driving record from that state to cover a total of the past five (5) year period. Include the out of state record with this application.*

Emergency Contact _____ **Phone** _____
Address _____ **Relationship** _____
Beneficiary _____ **Phone** _____
Address _____ **Relationship** _____

EDUCATION LEVEL – HIGH SCHOOL DIPLOMA, G.E.D. OR EQUIVALENT?..... YES ☐ **NO** ☐
You must be a high school graduate or have an equivalent education. Attach a copy of the diploma or transcripts.

COLLEGE?..... YES ☐ **NO** ☐
CREDIT HOURS _____ **DEGREES** _____

MILITARY SERVICE?..... YES ☐ **NO** ☐
IF YES, HOW LONG _____ **TYPE OF DISCHARGE** _____
If YES, you must provide a copy of your discharge papers. DD 214 or NGB 22.

Name: _____ Last 4 SSN: _____

PERSONAL RECORD

A poor driving record and/or certain criminal histories could be cause for rejection of your application. If you become a member/employee, periodic personal driving record and criminal history checks may be made by the department. You should also understand and agree that controlled substance (drug) testing may be required by the department as part of an accident investigation and/or on a periodic, unannounced basis. Refusal to participate in this testing or positive test results may result in your dismissal from the department. **YOUR DRIVING AND CRIMINAL RECORDS ARE CONFIDENTIAL**. Only those people directly involved in the application and eligibility process will have access to this information.

APPLICANTS MUST MAINTAIN VALID PROOF OF PERSONAL AUTO LIABILITY INSURANCE; ATTACH PROOF OR COPY.

LIST ALL TRAFFIC VIOLATIONS OR CHARGEABLE ACCIDENTS FOR THE PAST TEN (10) YEARS OR INDICATE NONE BELOW.

_____

_____

_____

DRIVING RECORD:

HAS YOUR DRIVER LICENSE EVER BEEN REVOKED OR SUSPENDED?..... YES ☐ NO ☐

IN THE LAST FIVE (5) YEARS HAVE YOU HAD AN APPLICATION FOR A DRIVER LICENSE DENIED?..... YES ☐ NO ☐

IN THE LAST FIVE (5) YEARS HAVE YOU BEEN CONVICTED OF:

WRECKLESS DRIVING?..... YES ☐ NO ☐

2 OR MORE MOVING VIOLATIONS?..... YES ☐ NO ☐

DUI OR DWI?..... YES ☐ NO ☐

CRIMINAL HISTORY

HAVE YOU EVER BEEN CHARGED OR CONVICTED OF A FELONY?..... YES ☐ NO ☐

IN THE LAST SEVEN (7) YEARS HAVE YOU BEEN CONVICTED OF A MISDEMEANOR?..... YES ☐ NO ☐

ARE YOU CURRENTLY ON OR EVER BEEN ON PROBATION OR PAROLE?..... YES ☐ NO ☐

ARE THERE ANY CRIMINAL CHARGES PENDING AGAINST YOU?..... YES ☐ NO ☐

*If you answered "**YES**" to any of the above four questions, please explain the circumstances on a separate sheet.*

Any changes to DRIVING RECORDS and CRIMINAL HISTORY must be reported to the department within 48 hours.

Applicant must provide a copy of DPS Licensee Driving Record (Type 3) and State History Check at uenroll.identogo.com (Service Code 11FT12). These reports shall not be dated more than 30 days prior to application submittal.

APPLICANTS SIGNATURE_____
DATE_____

Name: ______________________________ Last 4 SSN: ____________________

EMPLOYMENT HISTORY

List jobs in reverse order starting with your most recent job. List your work history for the last 8 years including volunteer, part-time, temporary, self-employment and military jobs. Provide a detailed description of duties performed. Do **NOT** substitute a resume for completion of this section. You may attach additional pages in the same format if more space is needed.

ARE YOU CURRENTLY EMPLOYED?.. **YES** ☐ **NO** ☐

EMPLOYER ______________________ **MAY WE CONTACT?**.......................... **YES** ☐ **NO** ☐

ADDRESS ______________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ______________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ______________________ **ELIGIBLE FOR REHIRE?** **YES** ☐ **NO** ☐

SUPERVISOR'S NAME ______________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____

DUTIES PERFORMED ____

____

EMPLOYER ______________________ **MAY WE CONTACT?**.......................... **YES** ☐ **NO** ☐

ADDRESS ______________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ______________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ______________________ **ELIGIBLE FOR REHIRE?** **YES** ☐ **NO** ☐

SUPERVISOR'S NAME ______________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____

DUTIES PERFORMED ____

____

EMPLOYER ______________________ **MAY WE CONTACT?**.......................... **YES** ☐ **NO** ☐

ADDRESS ______________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ______________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ______________________ **ELIGIBLE FOR REHIRE?** **YES** ☐ **NO** ☐

SUPERVISOR'S NAME ______________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____

DUTIES PERFORMED ____

____

Name: ____________________ Last 4 SSN: ____________________

EMPLOYMENT HISTORY CONTINUED

EMPLOYER ____________________ **MAY WE CONTACT?**......................... **YES** ☐ **NO** ☐

ADDRESS ____________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ____________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ____________________ **ELIGIBLE FOR REHIRE? YES** ☐ **NO** ☐

SUPERVISOR'S NAME ____________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____________________

DUTIES PERFORMED ____________________

____

EMPLOYER ____________________ **MAY WE CONTACT?**......................... **YES** ☐ **NO** ☐

ADDRESS ____________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ____________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ____________________ **ELIGIBLE FOR REHIRE? YES** ☐ **NO** ☐

SUPERVISOR'S NAME ____________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____________________

DUTIES PERFORMED ____________________

____

EMPLOYER ____________________ **MAY WE CONTACT?**......................... **YES** ☐ **NO** ☐

ADDRESS ____________________ **CITY** ____________ **STATE,ZIP** __________

YOUR JOB TITLE ____________________ **FROM** ____________ **TO** ____________

REASON FOR LEAVING ____________________ **ELIGIBLE FOR REHIRE? YES** ☐ **NO** ☐

SUPERVISOR'S NAME ____________________ **SUPERVISOR'S PHONE #** ____________

SUPERVISOR'S EMAIL ____________________

DUTIES PERFORMED ____________________

____

HAVE YOU APPLIED FOR A POSITION WITH ANOTHER AGENCY?...................................... **YES** ☐ **NO** ☐

IF YES, WHERE? ____________________

ADDITIONAL PAGES ATTACHED?.. **YES** ☐ **NO** ☐

Name: _____ Last 4 SSN: _____

JOB RELATED EXPERIENCE

ADDITIONAL FIREFIGHTER CERTIFICATIONS *Attach copies of all certification(s). (Applicant should keep original documents). i.e. NIMS CLASSES, TEEX CLASSES, PRO BOARD, NWCG, NFA, etc.*

EMERGENCY MEDICAL SERVICES (EMS) *Briefly describe your EMS experience and duties. Attach copies of all certification(s). (Applicant should keep original documents).*

TX. DEPT. OF HEALTH CERTIFICATION LEVEL (ECA, EMT, EMT-I, EMT-P) _____ NUMBER _____

Attach copies of EMS Certification(s). (Applicant should keep original documents). **EXPIRES _____**

ADDITIONAL SKILL SETS AND/OR QUALIFICATIONS YOU WOULD LIKE US TO KNOW

Name: _____ Last 4 SSN: _____

MEDICAL STATEMENT AND QUESTIONNAIRE

APPLICANT must include a signed AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FORM.
This form to remain confidential.

NAME _____ **DATE** _____

HOME PHONE _____ **CELL PHONE** _____

DATE OF BIRTH _____ **HEIGHT** _____ **WEIGHT** _____

DOCTOR'S NAME _____ **PHONE** _____

Please describe, in your own words, the general state of your physical health and mental well-being.

_____

_____

Firefighting, rescue operations and EMS activities can be physically and emotionally stressful.

Do you have any condition or disability that might prevent or restrict your activities?..... **YES** ☐ **NO** ☐

If **YES**, explain. _____

ANSWER EACH ITEM YES OR NO. EXPLAIN ANY "YES" ANSWERS ON THE LINES BELOW. IF ADDITIONAL SPACE IS REQUIRED, USE THE BACK PAGE AND REFER TO QUESTIONS BY LETTER REFERENCE.

A.	Do you have limited vision or blindness in either eye?.....	**YES** ☐	**NO** ☐
B.	Do you wear glasses or contact lenses? If yes, what is your uncorrected vision?	**YES** ☐	**NO** ☐
C.	Have you had a tetanus shot? If yes, provide date of last shot…….....	**YES** ☐	**NO** ☐
D.	Have you ever lived with anyone who had tuberculosis?.....	**YES** ☐	**NO** ☐
E.	Do you have any allergies?.....	**YES** ☐	**NO** ☐
F.	Have you ever attempted suicide?.....	**YES** ☐	**NO** ☐
G.	Are you taking any medication for a chronic condition?.....	**YES** ☐	**NO** ☐
H.	Have you used any illegal or illicit drugs in the last five (5) years?.....	**YES** ☐	**NO** ☐
I.	Have you ever been treated for a mental condition?.....	**YES** ☐	**NO** ☐
J.	Have you ever been denied life or health insurance?.....	**YES** ☐	**NO** ☐
K.	Have you ever been advised to have any medical procedure or surgery?.....	**YES** ☐	**NO** ☐
L.	Do you have any sensitivity to dust, sunlight, or chemicals?.....	**YES** ☐	**NO** ☐
M.	Have you been hospitalized within the past year?.....	**YES** ☐	**NO** ☐
N.	Are you unable to perform some motions, lift heavy objects or assume some positions?.....	**YES** ☐	**NO** ☐
O.	`Do you use tobacco products?.....	**YES** ☐	**NO** ☐
P.	Have you ever coughed up blood?.....	**YES** ☐	**NO** ☐
Q.	Are you under a physician's care for a communicable disease?.....	**YES** ☐	**NO** ☐
R.	Have you ever been knocked out or lost consciousness?.....	**YES** ☐	**NO** ☐

_____

_____

Name: _____ Last 4 SSN: _____

WORK RELATED PROFESSIONAL REFERENCES

Provide five (5) professional references that you have known at least five (5) years or more and are not related to you in any way. Application will not be accepted without five (5) references, all fields must be completed.

1) NAME: _____ JOB TITLE: _____

YEARS KNOWN: _____ (Check One) SUPERVISOR: ☐ OR CO-WORKER ☐ OR OTHER ☐

COMPANY NAME/JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

2) NAME: _____ JOB TITLE: _____

YEARS KNOWN: _____ (Check One) SUPERVISOR: ☐ OR CO-WORKER ☐ OR OTHER ☐

COMPANY NAME/JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

3) NAME: _____ JOB TITLE: _____

YEARS KNOWN: _____ (Check One) SUPERVISOR: ☐ OR CO-WORKER ☐ OR OTHER ☐

COMPANY NAME/JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

4) NAME: _____ JOB TITLE: _____

YEARS KNOWN: _____ (Check One) SUPERVISOR: ☐ OR CO-WORKER ☐ OR OTHER ☐

COMPANY NAME/JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

5) NAME: _____ JOB TITLE: _____

YEARS KNOWN: _____ (Check One) SUPERVISOR: ☐ OR CO-WORKER ☐ OR OTHER ☐

COMPANY NAME/JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

PERSONAL REFERENCES

Provide five (5) personal references whom you have known at least five (5) years or more, and are not related to you in any way, and who were not your employer or supervisor. Application will not be accepted without five (5) references, all fields must be completed.

1) NAME: _____ YEARS KNOWN: _____

OCCUPATION: _____ JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

2) NAME: _____ YEARS KNOWN: _____

OCCUPATION: _____ JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

3) NAME: _____ YEARS KNOWN: _____

OCCUPATION: _____ JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

4) NAME: _____ YEARS KNOWN: _____

OCCUPATION: _____ JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

5) NAME: _____ YEARS KNOWN: _____

OCCUPATION: _____ JOB TITLE: _____

ADDRESS: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

Name: _____ Last 4 SSN: _____

RELEASE OF PERSONAL INFORMATION

PLEASE READ THOROUGHLY AND CAREFULLY

THIS PAGE MUST BE FILLED OUT LEGIBLY IN BLACK INK, DO NOT TYPE

I _____ do hereby authorize a review and full disclosure of all records concerning me to any duly authorized agency of the Travis County ESD No. 12/Manor Fire Department whether the said records are of a public, private or confidential nature.

The intent of this authorization is to give my consent to full and complete disclosure of the records and educational institutions, financial or credit institutions (including records of loans), the records of commercial or retail credit agencies (including credit reports and or ratings and other financial statements and records wherever filed), medical records, polygraph records, employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me and the records and recollections of Attorneys at Law, or of other counsel, whether representing myself or another person in any case either criminal or civil, in which I presently have or have had interest. I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly (in whole or in part), upon this release authorization will be considered in determining my suitability for service by Travis County ESD No. 12/Manor Fire Department. I do hereby release said person(s) who provide information about me, whether supplied by a government organization or individual, from any and all liability, which may be incurred as a result of furnishing such information. A photocopy or fax copy of this release will be valid as an original thereof, even though the said photocopy or fax does not contain an original writing of my signature.

Applicant Signature _____

Applicant Address City, State, Zip _____

Applicant Date of Birth (DD/MM/YYYY) _____

Social Security Number _____-_____-_____ **Driver License State** _____ **Number** _____

This portion to be filled out by a Notary Public:

State of _____; County of _____. Before me, the undersigned Notary Public of the State of _____, on this day personally appeared _____, (Check one) _____ known to me; _____ proven to me on the oath of _____; or proved to me through _____ (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that s/he executed the same for the purposes and consideration expressed and in capacity expressed therein.

Given under my hand and seal of office on this _____ day of _____ 20 _____.

_____

Notary Public Signature and Personalized Seal/Stamp

Name: _____ Last 4 SSN: _____

ADDITIONAL APPICATION INFORMATION

Drug Free Work Environment: Travis County ESD No. 12 is committed to providing a safe, efficient, drug-free work environment for all employees. In keeping with this commitment, finalists for all job openings will be required to provide body fluids (blood or urine) to determine the use of alcohol, illegal or controlled substances. Failure of the drug/alcohol screen will result in denial of employment.

Falsification of Information: I hereby certify that all statements made on this application and attachments are true and correct to the best of my knowledge and belief. I understand that any false statement, misrepresentation or omission made by me on this application or subsequent interview(s) could cause me to be ineligible for employment or terminated from employment. I further understand that I am required to abide by all rules and regulations of Travis County ESD No. 12.

Verification of Information: I authorize Travis County ESD No. 12 and its agents to investigate and verify the facts claimed by me on this application. I further authorize my former employers to provide any information requested by Travis County ESD No. 12. I understand that employment processing may include a criminal background check, drug screening and/or review of my driving record. I hereby release Travis County ESD No. 12 and its agents from liability in making any investigation and inquiry relative to information contained in the application form.

I understand that nothing in this application or in any prior or subsequent written or oral statement creates a contract of employment or any rights in the nature of a contract. I agree to submit to a medical examination and drug screening, if required.

[Applicant's Initials _____] I HAVE READ AND AGREE TO THE ABOVE STATEMENTS

APPLICANT'S SIGNATURE_____ **DATE:** _____

APPLICANT'S NAME PRINTED AS SIGNED _____

DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

APPLICATION CHECKED FOR COMPLETION…… ☐
DRIVING RECORD…….. ☐
CRIMINAL HISTORY…….. ☐
COPY OF LIABILITY INSURANCE…… ☐
COPY OF DRIVER LICENSE…… ☐
COPY OF H.S. DIPLOMA OR EQUIVALENT…… ☐
COPY OF COLLEGE TRANSCRIPTS…….. ☐
COPY OF ALL CERTIFICATIONS…….. ☐
SIGNED RELEASE OF PERSONAL INFORMATION…….. ☐
HIPPA RELEASE FORM SIGNED…… ☐
MEDICAL STATEMENT…… ☐
REFERENCES CHECKED…… ☐

ADDITIONAL NOTES:

RECOMMENDED FOR EXAM……..... **YES** ☐ **NO** ☐

APPLICATION CHECKED BY_____ **DATE** _____
SIGNATURE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name: **Travis County Emergency Services District No. 12**
Address **P. O BOX 846**
City: **MANOR** State: **TX** Zip Code: **78653**
Phone: **(512) 272-4502** Fax: **(512) 428-5114**

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: **Travis County Emergency Services District No. 12**
Address **P. O BOX 846**
City: **MANOR** State: **TX** Zip Code: **78653**
Phone: **(512) 272-4502** Fax: **(512) 428-5114**

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ✔ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.