

AUTHORIZATION TO USE OR TO DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize **Armstrong Ambulance Service** to use or disclose the following protected information from the records of the client listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Client Name: _____ Date of Birth: _____
Address: _____

3. Information to be disclosed to: _____
Name

Address

City State Zip

4. Disclose the following information and attendance dates: _____ to _____.

___ Complete Records	___ Consult	___ Physical Therapy
___ Abstract	___ Outpatient Records	___ Emergency Reports
___ Face Sheets	___ X-Ray	___ Other (specified) _____
___ Discharge Summary	___ Laboratory	_____
___ History & Physical	___ Pathology	_____

5. The above information is disclosed for the following purposes:
___ Medical ___ Legal ___ Insurance ___ Personal ___ Other: _____

6. *I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.*

7. This authorization expires one year from the date of signature.

8. _____
Signature of Patient or Legal Representative

9. _____
Date

Printed name of Patient or Legal Representative

10. _____
Relationship to patient or authority to act for patient