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