AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize South Park Ambulance District to release medical information from the medical records of:

Patient Name: _____

Date of Birth:_____Social Security (last 4 digits only):_____

Patient Street Address: _____

City:_____State:_____Zip Code: _____

Date of Treatment Requested: _____

Information to be disclosed:

- ○ Medical Records (Patient Care Record)
- ○ Billing Records

The information may be disclosed to: Name: _____

Address: _____

City:_____State:_____Zip Code: _____

Email Address:_____

MEDICAL DISCLAIMER: I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

_____ _____

Signature of Patient Date of Signature

Please email this completed form to: chief@southparkambulance.com
In the email subject line please enter: Custodian of Records