AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

White Oak EMS

1. Patient Information

Please provide the information for the patient whose records are being requested.

Patient Name: _____

Date of Birth: _____ **Social Security # (Last 4):** _____

Address: _____

City, State, Zip: _____ **Phone Number:** _____

2. Authorized Receiving Party

I hereby authorize White Oak EMS to release the protected health information of the patient named above to the following individual or organization:

Name/Organization: _____

Attention: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____ **Email:** _____

3. Information to be Released

Please specify the records you are requesting and the dates the services were provided.

Date(s) of Service:

- ☐ Specific Date: _____
- ☐ Range of Dates: From _____ to _____
- ☐ All Dates of Service

Type of Information Requested (Check all that apply):

- ☐ Prehospital Patient Care Report (PCR)
- ☐ Billing / Itemized Statement Records
- ☐ EKG / Cardiac Monitor Strips
- ☐ Entire EMS Medical Record
- ☐ Other (Please specify): _____

4. Purpose of Disclosure

☐ At the request of the individual ☐ Continuation of Medical Care

☐ Legal Investigation / Representation ☐ Insurance Claim / Payment

☐ Other (Please specify): _____

5. Patient Rights & Acknowledgments

By signing this form, I understand and acknowledge the following:

- **Right to Revoke:** I have the right to revoke this authorization at any time by providing written notice to the White Oak EMS Privacy Officer, except to the extent that White Oak EMS has already taken action in reliance upon it.
- **Conditioning of Treatment:** White Oak EMS will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- **Potential for Redisclosure:** I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws (HIPAA).
- **Expiration:** Unless otherwise revoked, this authorization will expire one (1) year from the date of signature, or upon the following specific date, event, or condition: _____.

6. Signature

I have read and understand the terms of this authorization. I hereby authorize White Oak EMS to release my health information as described above.

Signature of Patient or Legal Representative: _____ **Date:** __

Printed Name of Patient or Representative: _____

If signed by a Legal Representative, please describe your authority to act on behalf of the patient (e.g., Parent of a minor, Power of Attorney, Executor of Estate). Please provide supporting documentation.

Relationship to Patient / Authority to Act: _____

Internal Agency Use Only

Date Received: _____ **Processed By:** _____

☐ Mail ☐ Fax ☐ Picked Up ☐ Secure

Date Sent: _____ **Method of Delivery:** Email