LeRoy Emergency Ambulance Service Inc.
Patient Authorization to Use and Disclose Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by LeRoy Emergency Ambulance Service Inc. of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

_____

_____

_____

This information may be used or disclosed by LeRoy Emergency Ambulance Service Inc. and may be disclosed to:

_____

I understand that I have the right to revoke this Authorization at any time, except to the extent that LeRoy Emergency Ambulance Service Inc. has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to LeRoy Emergency Ambulance Service Inc.'s HIPAA Compliance Officer:

Jason Freeman
303 S. East St.
LeRoy Il, 61752
309-962-6114
jfreeman@leroyambulance.org

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for LeRoy Emergency Ambulance Service Inc. to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by LeRoy Emergency Ambulance Service Inc. for the following purpose(s):

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to LeRoy Emergency Ambulance Service Inc. from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ ***Date:*** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Description of the authority of personal representative:

_____

Street Address: _____

City: _____State: _____ Zip Code: _____