HASKELL COUNTY AMBULANCE SERVICE

700 West LaLande – P.O. Box 980
Sublette, KS 67877
Phone: (620) 675 – 2485 – Fax: (620) 675 – 8487
E-Mail: HaskellCountyEMS@yahoo.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Request: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Social Security No: _____ Date of Birth: _____ Date of Service: _____

I, _____, hereby authorize Haskell County Ambulance to
(Name of Patient or Person making Request)

disclose/release the ☐ Patient Care Report ☐ Billing Information ☐ All health information,

to the following: (If different than patient)

Name of Person/Company: _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

The purpose of the use and/or disclosure of this protected health information is: _____

_____

This authorization shall expire on the 180th day after signing, unless otherwise specified below:

_____

I understand that I may revoke this authorization, in writing, at any time. I understand that my revocation will not be effective to the extent that the authorized entity has relied on the use or disclose of the protected health information. However, my revocation will be effective from the date of the revocation forward. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge that I have signed a consent form of the Haskell County Ambulance Service. I understand that I have the right to inspect or copy my protected health information to be used and/or disclosed as permitted under federal and/or state law. I understand I have the right to refuse to sign this authorization, and in doing so, this authorization will not be effective. I understand that I have the right to receive a copy of this authorization.

_____	_____	_____
Patient's Signature (Legal Guardian)	Relationship to Patient	Date

Subscribed and Sworn this _____ day of, _____, 20____.

Notary Seal

If Patient deceased, or not able to sign.
Death certificate or power of attorney must be provided.