HIPAA INFORMATION RELEASE AUTHORIZATION

Note: Signature is required in Two places.

CALLAWAY COUNTY AMBULANCE DISTRICT
PO BOX 246
FULTON, MO 65251

PRINT PATIENT'S FULL NAME			
PATIENT'S SOCIAL SECURITY NO.			
PRINT PATIENT'S DATE OF BIRTH		PATIENT'S PHONE NO.:	
PRINT STREET ADDRESS:			
PRINT CITY - STATE - ZIP			

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use or disclose information about me.

2. The following person (or class of persons) may receive disclosure of protected health information about me.:

PRINT HIS / HER / ITS NAME:		☐ Patient ☐ Authorized Representative
PRINT STREET ADDRESS:		
PRINT CITY - STATE - ZIP		

3. The specific information that should be disclosed is… (please give dates of service, if possible.)

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS OR MENTAL HEALTH WILL BE DISCLOSED.

☐ **YES, Disclose this information * (Signature Required Here) -**

☐ **NO, DO NOT DISCLOSE THIS INFORMATION * (Signature Required Here) -**

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Callaway County Ambulance District in writing of my desire to revoke it. I **UNDERSTAND THAT ANY ACTION ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION CANNOT BE REVERSED AND MY REVOCATION WILL NOT AFFECT THOSE PRIOR ACTIONS**.
6. My purpose/use of the information is for:
7. This authorization expires on _____, **20___** OR upon occurrence of the following event that relates to me or to the purpose of the indended use or disclosure of information about me.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

↑ SIGNATURE OF INDIVIDUAL (The person about whom the information relates) ↓ OR IF APPLICABLE ↓	↑ Date of Individuals Signature	↑ Date of Birth or Social Security Number
↑ SIGNATURE OF GUARDIAN * OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE	↑ Date of Guardian's/Personal Representative's Signature	↑ Description of Authority to Act for the Individual

A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE GIVEN TO THE INDIVIDUAL OR OTHER SIGNATORY