



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rules (federal regulations that became effective April 14th, 2003) provide important protection for health information including that your authorization is obtained in certain circumstances. The Privacy Rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

INSTRUCTIONS: Fill out form completely and accurately. Be sure to sign this document and mailed it to DVA Ambulance, Inc. along with a copy of any supporting documentation, i.e. Birth Certificate, Power of Attorney, Death Certificate and/or Photo Identification (Required). IF not completed completely or accurately, this request will be rejected.

Name Social Security #
Birth Name Date of Birth
Address City/State/Zip
Telephone Fax

I herby authorize the release of my medical information related to:

SERVICE DATE: CALL NUMBER (IF KNOWN):

From/To: DVA Ambulance, Inc. From/To:
308 N Saginaw St.
Durand, MI. 48429

Purpose for this disclosure:
Insurance Other (please specify)

I understand that my personal health information may include medical records created or received by EMS personnel, including records regarding emergency medical care; non-emergency medical care; records from other agencies and medical care facilities; and billing information. I authorize the release of this information to the individual or organization listed above only under the conditions listed below.

If not revoked, this authorization is valid until it expires six months from the date signed below or until the following date or event: (MM/DD/YYYY)

I understand that I may revoke this authorization at any time, but I must do so in writing and sent to the Privacy officer of DVA Ambulance, Inc. The revocation will not be effective to the extent that DVA Ambulance, Inc. has already disclosed the information. I understand that the information disclosed is subject to re-disclosure and will no longer be protected by the federal Privacy Rules, 45 C.F.R. Parts 160 and 164.

I understand that I have the right to receive a copy of this authorization after it has been signed. A copy or fax of this authorization may be used in lieu of this original.

PATIENT SIGNATURE (or legal representative) Date
Description of legal representative authority (if any):

SIGNATURE AND COPY OF PHOTO ID REQUIRED

Method: Mailed Picked up Faxed Run #:
Sent by: Date: