AUTHORIZATION TO RELEASE Protected Health Information (PHI)
(MEDICAL AND MENTAL HEALTH INFORMATION)

The execution of this form does not authorize the release of information other than that specifically described below:

To: **Northglenn Ambulance, Inc.** Date of Request: ______________________

Please Print all information. Illegible handwriting may delay your request.

Patient: ____ Birth Date: _______________________

Address: ____

Street City State Zip

Requesting Party (if other than patient) ____

Relationship to patient: ____

Date of Transport: ________________________ Address/Location of Transport: ____

Release Information to: ___________________________________Self as part of an existing PHI with Northglenn Ambulance

I request and authorize Northglenn Ambulance, Inc. to release the information specified below to the organization, agency, or individual named on this request. I understand that the information to be released includes information regarding the following conditions:

____Drug Abuse, if any ____Alcoholism, or alcohol abuse, if any ____Psychological/psychiatric conditions, if any

____Sickle Cell Anemia, if any ____Any other chronic medical conditions, if any

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Information Requested:

_____Copy of Medical Trip Report, history & physical reports _____Copy of Charges

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Purpose(s) or need for which information is to be used:

_____Damage or claim evaluation/presentation

_____Other (Must be specified) ____

AUTHORIZATION – I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event if revoked in writing by patient or by person authorized to sign for patient. I understand that pursuant to the HIPAA Privacy Regulation a covered entity cannot condition the provision of treatment, payment of health plan benefits, or eligibility for such benefits on the signing of an authorization. No such condition has occurred regarding this authorization. I understand that if the provider is covered by the HIPAA Privacy regulation, once the provider discloses the protected health information it may no longer be protected by the regulation.

Patient/Requesting party authorized to sign Date

Other Conditions – A copy of this authorization or my signature thereon may be utilized with the same effectiveness as an original.

**A clear copy of a photo ID must accompany this request.*