Patient Authorization

Cole County Emergency Medical Services
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 Cole County Emergency Medical Services 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 Cole County Emergency Medical Services and may be disclosed to:

_____

_____

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

David Boyles
1736 Southridge Drive
Jefferson City, MO 65109
(573) 634-5678
dboyles@colecounty.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 Cole County Emergency Medical Services 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 Cole County Emergency Medical Services for the following purpose(s):

_____

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Cole County Emergency Medical Services 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: _____