

**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

Information Requested: _____

___ Copy of Medical Trip Report, history & physical reports ___ Copy of Charges

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.