

# 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 Taney County Ambulance District 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 Taney County Ambulance District and may be disclosed to:

\_\_\_\_\_  
\_\_\_\_\_

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

Matthew Aumiller  
PO Box 460  
Branson, MO 65615

417-334-6586  
matt@tcad.net

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.

# Patient Authorization to Use and Disclose Protected Health Information



I understand that my written authorization is not required for Taney County Ambulance District 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 Taney County Ambulance District for the following purpose(s):

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The use or disclosure of the requested information will \_\_\_/will not \_\_\_ result in direct or indirect remuneration to Taney County Ambulance District 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:

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Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_