Hartford HealthCare
Emergency Medical Services
HUNTER'S AMBULANCE

HUNTER'S AMBULANCE SERVICE, INC.

Authorization to Use and Disclose Protected Health Information PHI

(This authorization must be fully completed, signed and dated)

This Authorization concerns the following medical information about me:

This information may be used or disclosed by Hunter's Ambulance Service, Inc. and may be disclosed to:

Information about diagnosis or treatment for alcohol/substance abuse and HIV/AIDS may be disclosed as follows: Check all that apply.

- ☐ Yes, Disclose HIV/AIDS information.
- ☐ No, do NOT disclose HIV/AIDS information.
- ☐ Yes, disclose alcohol/drug abuse information.
- ☐ No, do NOT disclose alcohol/drug abuse information.

This Authorization is being requested for the following purpose (s):

Date of Event

Date of Birth

I understand that I have the right to revoke this Authorization at any time except to the extent that Hunter's

Ambulance Service, Inc. has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Hunter's Ambulance Service, Inc. Privacy Officer.

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 any written authorization is not required for Hunter's Ambulance Service to use my protected health information for treatment, payment and health care 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.

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I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations

Any fax, copy or photocopy of this Authorization shall authorize Hunter's Ambulance Service, Inc. to release my records.

This Authorization expires on: _____

Dated: _____

Signature of Patient or Personal Representative _____

Printed Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority to Sign for Patient (attach documents that show authority)