AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:_____ **Date of Birth:** _____
Last **First** **Middle**

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct Marion Emergency Medical Services to disclose my ambulance report form to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom Marion Emergency Medical Services may disclose my ambulance report from _____ (Date of service)
_____. Address of the recipient or where my health information should be delivered:
_____.

Purpose: I understand that the specific purpose of this Authorization is
_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Redisclosure: I understand that once Marion Emergency Medical Services discloses my health information to the recipient identified above, Marion Emergceny Medical Services cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization.

Questions: I may contact the Marion EMS for answers to my questions about the privacy of my health information at (508) 748-1212.

_____ _____
Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness