EAGLE COUNTY
PARAMEDIC SERVICES

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Eagle County Health Service District A/K/A Eagle County Paramedic Service to release medical information from the medical records of:

Patient Name: ____

DOB: _________________ Social Security (last 4 digits only):___________________

Patient Street Address: ______________________________________

State:______________________________________ Zip code: __________

Date of Treatment requested: ___________________________________

Information to be disclosed:

- ○ Medical Records (patient care record)
- ○ Billing Records

The information may be disclosed to: Name: _______________________________________

Address: ______________________________________

City: _______________ State: ______Zip code: ______

MEDICAL DISCLAIMER: I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

_________________________________ Signature of patient or personal representative

________________ Date of signature