DEWEY FIRE COMPANY NO.1 AMBULANCE

502 Durham Street, Hellertown, PA 18055

610-838-1677 610-838-1688(fax)

AUTHORIZATION FOR RELEASE OF EMERGENCY MEDICAL SERVICES REPORT

The Dewey Fire Company No.1 Ambulance emergency medical services report contains confidential information including medical histories, reports of actions and findings, summaries, diagnoses, records of treatment, medications ordered and administered, notes, entries other written or graphical material maintained by Dewey Fire Company No.1 Ambulance pertaining to the individual receiving the emergency medical care. By signing below I authorize Dewey Fire Company No.1 Ambulance to release my emergency medical services report(s) to:

Patient's Name: _____

Patient's Address: _____

_____

Phone: _____ Date of Birth: _____

I AUTHORIZE Dewey Fire Company No.1 Ambulance to use and disclose the protected health information described below to:

NAME & ADDRESS: _____

_____

_____

This authorization for the release of information covers the entire emergency medical services report, including the release of demographics, diagnostic information (EKG's, vital signs), etc.

☐ I authorize the release of my complete emergency medical report(s)
Report(s) released cover a time period from _____
to _____.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billings or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest this claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

I understand that once received, records will be released within 5 business days. This authorization will expire once acted upon.

There is a $25.00 copying & processing fee for each report.

Emergency medical records will not be released without the signature of the patient. If the patient is unable to sign (minor, deceased, physically or mentally incapacitated, etc.), a legal qualified representative (parent, guardian, Power of Attorney, executor of estate, etc.) may sign in lieu of the patient. Proof of representation must accompany this request. **All signatures must be notarized.**

Signature of Patient: _____

Date: _____

Signature of Representative: _____

Printed Name: _____

Date: _____ Relationship to Patient: _____

NOTARY: