EMS|MC

Patient Authorization | HIPAA Form

Completed form may be sent via Fax: 336.740.9773 or via e-mail: einfo@emsbilling.com

PATIENTS INFORMATION

_____ Full Name

_____ Date of Birth

_____ City, State, Zip Code

_____ Run Number

_____ Provider (EMS Agency)

AUTHORIZATION

I hereby authorize EMS Management & Consultants, Inc. to use or disclose the following Protected Health Information: Ambulance Call Report and/or Bill(s).

This may be used to disclose to: _____

The purpose for the use or disclosure is: _____

DISCLOSURE

I understand that I have the following rights:

- To inspect and copy the information to be used or disclosed according to this authorization.
- To revoke this authorization at any time except for instances where EMS Management & Consultants, Inc.
- has already used or disclosed information subject to this authorization.
- To revoke this authorization, I must provide written notice to:

  Privacy Officer
  EMS Management & Consultants, Inc.
  PO Box 863
  Lewisville, NC 27023
  Phone: 800.814.5339 | Fax: 336.740.9773 | E-mail: einfo@emsbilling.com

Information used or disclosed according to this authorization may again be disclosed by the recipient. This information is no longer protected by privacy law.

Written authorization is not required for treatment, payment or healthcare operations. I have read this authorization and I understand I have the right to refuse to sign it. I understand and agree to the terms of this authorization.

This form implements the requirements for patient authorization to use & disclose health information protected by the federal health privacy law, 45 CFR, parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 CFR, 164.508(c).

_____ Patient's Signature

_____ Date Signed

Or, if applicable check Next of Kin if you are and if patient is deceased

_____ Next of Kin Personal Representative Signature

_____ Relationship to Patient

_____ Date Signed