Elko County Ambulance Service
Patient Authorization to Use and Disclose Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by Elko County Ambulance Service of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

_____

_____

_____

This information may be used or disclosed by Elko County Ambulance Service and may be disclosed to:

_____

_____

I understand that I have the right to revoke this Authorization at any time, except to the extent that Elko County Ambulance Service has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Elko County Ambulance Service's HIPAA Compliance Officer:

Chris McHan, NREMT-P
540 Court St., Ste 101
Elko, NV 89801
775-738-8046
cmchan@elkocountynv.net

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 my written authorization is not required for Elko County Ambulance Service to use my protected health information for treatment, payment and healthcare operations.

Elko County Ambulance Service
Patient Authorization to Use and Disclose Protected Health Information

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. The Authorization is being requested by Elko County Ambulance Service for the following purpose(s):

_____

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Elko County Ambulance Service from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ ***Date:*** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Description of the authority of personal representative:

_____

_____

Street Address: _____

City: _____State: _____ Zip Code: _____