Suffield Volunteer
Ambulance Association

PO Box 642 205 Bridge Street Suffield, CT 06078 Phone 860-668-3881 Fax 860-668-3884

HIPAA Release of information
AUTHORIZATION FORM

Patient Name: _____

Address: _____

I hereby authorize **Suffield Volunteer Ambulance Association** to release the above named individual's personal care report and billing information to

Recipient Name and address:

_____

For the ambulance call on (Date) _____
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and shall expire after one year from that date.

I understand that I have a right to revoke this authorization by providing written notice to Suffield Volunteer Ambulance Association. However, this authorization may not be revoked if Suffield Volunteer Ambulance has action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Signature: _____ **Date:** _____

Printed Name: _____

If applicable, Legal Representatives sign below:

> ***By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.***

Name of Legal Representative: _____

Signature of Legal Representative: _____**Date:** _____