Account #_____Patient's Contact Phone #_____

McMinnville Ambulance
Authorization to Use and Disclose
Specific Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by City of McMinnville Ambulance Service of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me: _____

_____

_____

This information may be used or disclosed by McMinnville Ambulance and may be disclosed to: _____

_____

_____

(LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU MAY MAKE THE REQUESTED USE/DISCLOSURE)

I understand that I have the right to revoke this Authorization at any time except to the extent that City of McMinnville 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 the McMinnville Ambulance Privacy Officer, Dale Mount, EMS Chief, 175 NE First St., McMinnville, Oregon, 97128.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for City of McMinnville Ambulance Service to use my protected health information for treatment, payment and health care operations.

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 City of McMinnville 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 City of McMinnville 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.

_____(Name) _____(Date)

_____(Description of the authority of personal representative, if applicable)

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