Livingston County EMS
Authorization to Use and Disclose
Specific Protected Health Information HF-006

PATIENT NAME: _____ _____
Last First Middle Initial Birth Date

ADDRESS: _____ _____
Phone

I understand that as part of my health care, I must authorize Livingston County EMS to use or disclose my health information. I hereby authorize Livingston County EMS to release or obtain specific medical records to the following individual or entity:

Name _____

Address _____

City, State, Zip _____

Name and address of person(s) or Organization(s) to whom Information is requested for.

This Authorization concerns the following medical information about me:

_____

_____

_____

This authorization will expire on _____ or when the reason for this authorization has expired.
That reason is: _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING, EXCEPT TO THE EXTENT THAT THE LIVINGSTON COUNTY EMS HAS ALREADY TAKEN ACTION IN RELIANCE ON MY CONSENT. MY REVOCATION OF THIS AUTHORIZATION MUST BE PROVIDED IN WRITING TO:

Livingston County EMS Privacy Officer
Assistant Director
3950 W. Grand River
Howell, Michigan 48855
(517) 546-6220

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 Livingston County EMS to use my protected health information for treatment, payment and health care operations.

I have read the above, and acknowledge that I fully understand the terms and conditions of this Authorization. I understand that the Livingston County EMS may not require me to sign this Authorization as a condition for treatment, payment, enrollment or eligibility for benefits.

_____	_____
Signature of Patient or Legal Representative	Witness
_____	_____
Date	Date

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* Consent by Person Other than Patient *

If patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I hereby certify, that I am the _____ of the patient. The patient is unable to consent
(Relation to Patient)
because he/she is a minor, or because _____

_____

On behalf of the Patient, I consent to the disclosure as stated above.

Date:_____ _____
Signature of parent, guardian, executor, administrator, etc.

Date:_____ _____
Witness

<u>* Legal documentation must be presented authorizing person to sign on Patient's behalf.</u>