AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Individual Name: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

Date of Birth: _____ Run Report Number: _____

2. By signing this Authorization, I hereby authorize Superior to disclose my health information to the following recipient (insert name of recipient):

_____

3. Information to be disclosed:

- ☐ Demographic
- ☐ Claims
- ☐ Physician certification statements
- ☐ Other (specify): _____
- ☐ Entire Record (specific justification): _____
- ☐ Call take records
- ☐ Run reports
- ☐ Dispatch records

The following sensitive information **WILL BE DISCLOSED** unless checked below:

- ☐ Alcohol/drug abuse treatment
- ☐ HIV test results and related treatment
- ☐ Sexually transmitted or other communicable diseases
- ☐ Pregnancy or birth control
- ☐ Mental health
- ☐ Developmental disabilities
- ☐ Genetic
- ☐ Sexual assault/abuse

4. Date(s) of information to be disclosed: From: __/____/____ To: __/____/____. If left blank, only information from approximately the past two (2) years will be disclosed.

5. The purpose of this disclosure is:

☐ Continuing care ☐ Litigation/legal ☐ Insurance eligibility/benefits

☐ Other (please specify): _____

6. Your Rights With Respect to this Authorization:

- I understand that I have the right to inspect and copy the information that is to be disclosed as part of this Authorization.

- 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 this Authorization will not affect any uses or disclosures that do not require my written authorization.

- I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this Authorization or to the extent that other action has been taken in reliance upon my Authorization. To revoke this Authorization, I understand that I must do so by written request to Superior's HIPAA Privacy Officer:

HIP AA Privacy Officer
Paramedic Billing Services
395 W. Lake St.
Elmhurst, IL 60126
hipaamail@superiorambulance.com

- I understand that this Authorization is voluntary. I understand that Superior may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this Authorization unless the services are being provided solely for the purpose of disclosing the information to a third party.

- Unless another expiration date, event, or condition is specified, this Authorization will expire in one (1) year.

Fill out if desired expiration is less than a year from signature date: This authorization expires on: _____ (date, event, or condition).

- I understand that Superior/PBS incurs costs when disclosing information, such as labor, supplies, and postage, and that I may be charged a reasonable, cost-based fee where permitted by law.

- I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the Authorization.

By signing this Authorization, I am authorizing the release of all records applicable to this request as outlined above. (E-Sign not accepted).

_____ Date:_____

Signature

If signed by a Legal Representative, complete the following:

1. The Individual is: □ a minor □ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent* □ legal guardian □ next of kin/executor of deceased □ activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.

Return Instructions:

Scan the QR code on the bottom of this document and select your "Reason for Contact" as Records and Legal Requests and follow the subsequent questions to ensure your request is properly received and processed.