CITY OF PULLMAN AMBULANCE

620 S. Grand Ave ◆ Pullman, WA 99163 ◆ Phone: 509-332-8172 ◆ Fax: 509-332-4460

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please read all information and instructions carefully before signing the authorization form.

Patient's Name _____ Birth date _____
(Please Print)

Are medical records filed under another name? _____ Phone Number _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below. I hereby authorize the use or disclosure of my personal health information as follows:

INFORMATION RELEASED BY: ☐ City of Pullman Ambulance Department
REASON FOR REQUEST: ☐ Personal ☐ Insurance ☐ Legal Review ☐ Other: _____
INFORMATION TO BE RELEASED TO: _____
Self/Organization/Person Name *Phone Number*

_____
Street Address *City/State* *Zip*

TYPE OF MEDICAL INFORMATION REQUESTED:

☐ Complete medical record for date range of: _____ to: _____
☐ My health information relating only to the following treatment or condition: _____
☐ My health information only for the following date or Run #: _____

I understand that:

➔ Authorizing the disclosure of this healthcare information is voluntary ➔ I can cancel this authorization at any time by writing to the City of Pullman Ambulance Department ➔ I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled ➔ Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

This authorization will expire: _____ or in ninety (90) days if not otherwise specified.

Patient signature: _____ Date: _____
(Please provide a copy of your photo ID)

Parent or Legal Guardian: _____ Date: _____

Relationship to patient, if other than patient: _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)