DATE:
TIME:
LOC:

LIFE ems®
AMBULANCE

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Life EMS Ambulance and its affiliates ("Life EMS") to use and/or disclose the following PHI to: _____: (Describe specifically the information to be used and/or disclosed,
Name of individual or entity to receive the PHI
such as date(s) of service, type of services, demographic information, origin of information): _____

which may include information about communicable diseases and serious communicable diseases and infections as defined by Michigan statute and rules which include venereal disease "VD", tuberculosis "TB", human immunodeficiency virus "HIV", acquired immunodeficiency syndromes "AIDS", and AIDS related complex "ARC"; alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations Part 2; or mental health treatment records, psychological and social services records including communications made by me to a social worker, psychiatrist or psychologist.

The purpose of this use and disclosure is at my request unless another purpose is stated here. (Describe the purpose or purposes for which the Ambulance Company will use and/or disclose the PHI, such as sending the PHI to the local high school if the patient was injured at a high school sporting event. If the purpose is a research study, this form must not include any other purposes): _____

Life EMS will ☐ will not ☐ receive payment or other remuneration from _____
Name of entity to receive the PHI
or any other third party in exchange for the use and/or disclosure of the PHI.

- I understand that the purpose (s) of the use and/or disclosure are set forth so that I can make an informed decision about whether to allow the use and/or disclosure of the PHI.
- I understand that I have the right to refuse to sign this authorization.
- I understand that I do not have to sign this authorization in order to receive treatment, except research related treatment, from Life EMS.
- I understand that when Life EMS uses and/or discloses my PHI in accordance with this authorization, the recipient may redisclose the information to other persons and the information may no longer be protected by federal or state laws.
- I understand that I have the right to revoke this authorization at any time in writing except to the extent Life EMS has acted in reliance upon this authorization.
- I understand and agree that my written revocation must be submitted to the Privacy Officer at the following address: 1275 Cedar Street NE, Grand Rapids, MI 49503.
- A faxed signature to Ambulance Company shall be valid as an original.

This authorization expires one year from the date it is signed, unless another expiration date or event is written here: _____. (Expiration Date or Occurrence of Defined Event. It is sufficient to state "end of research study", "none" or similar language if authorization is for use or disclosure of PHI for research.)

Patient Name: _____ Patient SS#: _____

Signed by: _____ Date: _____
Signature of Patient or Patient's Personal Representative

Personal Representative's Name (if applicable): _____
Print or Type

Description of Personal Representative's authority to act on behalf of patient: _____

PATIENT OR PERSONAL REPRESENTATIVE MUST BE PROVIDED A COPY OF SIGNED AUTHORIZATION

REV 04/03

Authorization Form Issued __/__/__