OSWEGO COUNTY AMBULANCE AND HEARSE SERVICE
PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I UNDERSTAND THAT IF MY HEALTH INFORMATION IS USED OR DISCLOSED, THE RELEASED INFORMAITON MAY NO LONGER BE PROTECTED BY PRIVACY REGULATIONS ISSUED BY THE FEDERAL GOVERMENT.

Patient Name_____

Social Security Number_____ DOB_____

By signing this form I hereby authorize Oswego County Ambulance and Hearse Service to disclose or release of all health medical records and billing information to persons identified below:

Persons authorized to receive the information (If Spouse or Relative please give their full name, address, and their relationship to you):

The patient or patients legal representative must read and initial the following statements:

A. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

Initials:_____

B. I understand that I may see and copy the information described on this form if I ask for it, and that Oswego County Ambulance and Hearse Service will give me a copy of this form after I sign it.

Initials:_____

C. I understand that this authorization will not expire. Initials: _____

D. I understand that I may revoke this authorization at any time by notifying Oswego County Ambulance and Hearse Service in writing, but if I do revoke it, the revocation will not have any effect on any actions Oswego County Ambulance and Hearse Service took before it received the revocation. Initials:_____

_____ _____
Signature of patient Date

_____ _____
Signature of patient's legal representative (POA) Date

If signed by representative Printed name of patient's representative:_____

Representative's relationship to patient:_____

Representative's relationship to patient: Copy of Power of Attorney attached_____Yes