Rehoboth Ambulance Committee, Inc

PO Box 156
Rehoboth, MA 02769

AUTHORIZATION TO RELEASE HIPAA PROTECTED INFORMATION

I hereby authorized **REHOBOTH AMBULANCE COMMITTEE** to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state laws protecting its confidentiality.

Patient Name:	
Patient Date of Birth:	
Patient Address:	

Person receiving information:	
Method of transmission:	_____Fax _____Email _____ Mail
Email, Fax or Address to send information to:	

Please disclose all **Ambulance Run Reports** for the following treatment dates:

_____ to _____

The information is being disclosed for the following purposes:

____ Medical Care ____ Legal ____ Insurance ____ Personal ____ Other _____

This authorization expires one year from today

I understand I may revoke this authorization at any time by requesting such of the **REHOBOTH AMBULANCE COMMITTEE** in writing, unless action has already been taken in reliance upon it, or during a contestability period under application lawy.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

This request must be submitted in writing to the Rehoboth Ambulance Committee via mail and must include an administrative fee of $25.00 made payable to the Rehoboth Ambulance Committee