County Ambulance, Inc.
Authorization to Use and Disclose
Specific Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by County Ambulance, Inc. of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

_____
_____
_____

This information may be used or disclosed by County Ambulance, Inc. and may be disclosed to:

_____
_____

I understand that I have the right to revoke this Authorization at any time except to the extent that County Ambulance, Inc. has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the County Ambulance, Inc. Privacy Officer Luanne Weiskotten 185 Wahconah St. Pittsfield, MA 01201 (413)499-2527

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 my written authorization is not required for County Ambulance, Inc. to use my protected health information for treatment, payment and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by County Ambulance, Inc. for the following purpose(s):

_____
_____
_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to County Ambulance, Inc. from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

_____ [Name] _____[Date]

_____ [Description of the authority of personal representative, if applicable]

This authorization expires on: _____ (date or event).