Authorization to Use and Disclose Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by The Adair County Ambulance District 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 the Adair County Ambulance District and may be disclosed to:

_____

_____

[LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU MAY MAKE THE REQUESTED USE/DISCLOSURE.]

I understand that I have the right to revoke this Authorization at any time except to the extent that the Adair County Ambulance District has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Adair County Ambulance District Privacy Officer:

Larry D. Burton, CAO
Adair County Ambulance District
606 W Potter Ave
Kirksville, MO 63501
660.665.0000

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 the Adair County Ambulance District 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 the Adair County Ambulance District for the following purpose(s):

_____

_____

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to the Adair County Ambulance District 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).