

JIM M. COPPINGER
COUNTY MAYOR



KENNETH L. WILKERSON
DIRECTOR
EMERGENCY MEDICAL SERVICES

HAMILTON COUNTY, TENNESSEE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION HAMILTON COUNTY EMERGENCY MEDICAL SERVICES

PATIENT NAME _____ BIRTHDAY ____/____/____

SOCIAL SECURITY NUMBER _____ - _____ - _____

ADDRESS _____
Street City State Zip Code

SEND INFORMATION TO: (please be specific)

Name/Organization

Address

PURPOSE OF RELEASE: Continuation of Care Specialist Personal Use Legal Other

INFORMATION TO BE RELEASED: Ambulance Run Reports dated _____ Refusal of Transport EKG strips

Expiration date for expressed authorization is _____. If a specific date or event is not specified, this authorization will expire ninety (90) days from the date signed by the patient or legal representative. I understand that I may revoke this authorization in writing at any time, providing the information has not already been released. I understand my treatment is not based on signing this authorization. I understand that once information is released per my instructions, the information is subject to redisclosure and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature

Date

Relationship to patient (if other than patient)

STATE OF _____

COUNTY OF _____

Subscribed and sworn before me, I _____, a Notary Public, in and for the County and State above, do hereby declare that the Affiant, _____ to me adequate identification of proving their identity and stated that _____ (he/she) did sign this document of their own free will, on this the _____ day of _____, 20____.

(AFFIX SEAL)

Notary Public

My Commission expires: _____