New Britain Emergency Medical Services, Inc.
225 Arch Street
New Britain, Connecticut 06050-2018
Authorization to Use and Disclose
Specific Protected Health Information

By signing this Authorization, I _____, hereby direct the use or disclosure by New Britain Emergency Medical Services, Inc.,[New Britain EMS] of certain medical information pertaining to my health, my health care or me.

This Authorization concerns the following medical information about me. [Please circle and fill in the date(s)].

A.	**Date of Service:**	**____/____/____**
B.	**Pre-Hospital Patient Care Record:**	**Yes / No**
C.	**Ambulance Service Billing Invoice:**	**Yes / No**
D.	**Patient's Mailing Address:** _____	

This information may be used or disclosed by New Britain EMS and may be disclosed to the following individual/organization/corporation/or law firm inclusive of name and mailing address:

I understand that the medical information disclosed pursuant to this authorization may include information related to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about psychiatric and/or other mental health conditions and related services that I have received; as well as treatment that I have received for drug and/or alcohol abuse.

I have the right to revoke this Authorization at any time except to the extent that New Britain EMS has already acted in reliance on the Authorization. To revoke this Authoriz ation I understand that I must do so by written request to the New Britain EMS Privacy Officer, Bruce Baxter.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written Authorization is not required for New Britain EMS to use my protected health information for treatment, payment and health care operations. I also understand that New Britain EMS may not condition treatment or payment on my signing this Authorization.

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 of New Britain EMS for the following purpose(s): **[Please state the reason for this request]:**

The use or disclosure of the requested information will _____/will not _____ result in the direct or indirect remuneration to New Britain EMS from a third party.

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

_____ _____ _____
Patient's Name Patients Date of Birth Date of Authorization

_____
Patient's Signature

_____
Description of the Authority of the personal Representative, if applicable. [Power of Attorney/Health Care Proxy/Guardian/Parent]

This Authorization expires on _____ (date or event) unless otherwise specified this authorization will expire One [1] year from the date it was signed.

_____
Signature of Authorizing Party
Form 600-103BE