



New Britain

EMERGENCY MEDICAL SERVICES, INC.

"Serving the needs of the community since 1977"

Authorization to Use and Disclose Specific Protected Health Information

By signing this Authorization, I, _____, 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 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 Authorization, 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 explain how this information will be used in the space below]:

The use or disclosures of the requested information will ___/will not ___ result in direct or indirect remuneration to New Britain EMS 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.

_____ [Printed Name] _____ [Date of Birth] _____ [Date of Authorization]

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

This authorization expires on: _____ (date or event) this authorization will expire 1 year from the date it was signed.

Signature of Authorizing Party

Form 600-103B