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**AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTHCARE INFORMATION**

By signing this Authorization, I hereby direct the disclosure by Professional Ambulance 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 disclosed by Professional Ambulance 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.E. ATTORNEY]

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

I understand that information 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 Professional Ambulance 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.

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.

Signature of Patient or Personal Representative: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Print Name: \_\_\_\_\_

Description of the authority of personal representative, if applicable: \_\_\_\_\_

This authorization expires on: \_\_\_\_\_ (date or event).