PRINT PATIENT'S FULL NAME			
PATIENT'S SOCIAL SECURITY NO.			
PRINT PATIENT'S DATE OF BIRTH		PATIENT'S PHONE NO.:	
PRINT STREET ADDRESS:			
PRINT CITY - STATE - ZIP			

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to use or disclose information about me.

2. The following person (or class of persons) may receive disclosure of protected health information about me.:

PRINT HIS / HER / ITS NAME:		Patient Authorized Representative
PRINT STREET ADDRESS:		
PRINT CITY - STATE - ZIP		

3. The specific information that should be disclosed is… (please give dates of service, if possible.)

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS OR MENTAL HEALTH WILL BE DISCLOSED.

- [ ] YES, Disclose this information *
- [ ] NO, DO NOT DISCLOSE THIS INFORMATION *

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying MetroAtlanta Ambulance Service in writing of my desire to revoke it. I UNDERSTAND THAT ANY ACTION ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION CANNOT BE REVERSED AND MY REVOCATION WILL NOT AFFECT THOSE PRIOR ACTIONS.
6. My purpose/use of the information is for:

7. This authorization expires on _______________, **2015** OR upon occurrence of the following event that relates to me or to the purpose of the indended use or disclosure of information about me.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Note: Signature is required in Two places.

↑ SIGNATURE OF INDIVIDUAL (The person about whom the information relates) ↓ OR IF APPLICABLE ↓	↑ Date of Individuals Signature	↑ Date of Birth or Social Security Number
↑ SIGNATURE OF GUARDIAN * OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE	↑ Date of Guardian's/Personal Representative's Signature	↑ Description of Authority to Act for the Individual

A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE GIVEN TO THE INDIVIDUAL OR OTHER SIGNATORY