Washington Ambulance Association, Inc.
Serving Washington Since 1942

109 Bee Brook Road
P.O. Box 294
Washington Depot, CT 06794
washingtonambulance.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFO	
	Patient Name:
	Patient Date of Birth:
	Parent's Name (if minor)
	Telephone(s)
	Street:
	Town/City/Zip:
	Reason for Ambulance Dispatch:
	Incident Date: Pick-up Location:

RELEASE INFO TO	
	Name:
	Street:
	Town/City:
	State/Zip

MUST BE COMPLETE & SIGNED FOR AUTHORIZATION

I hereby authorize the release of my own or my child's records described above for the purpose of:
☐ At the request of the patient ☐ Other (in detail): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. You are hereby *specifically authorized to release* all information or medical records related to such diagnosis, testing, or treatment.
I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

This authorization will expire: _____ or in ninety days if not otherwise specified.

_____ _____
Patient signature *(proper identification may be required for verification)* today's date

_____ _____
Patient's Representative if unable to sign (printed name + signature) today's date

check one: ☐ Patient's Parent ☐ Patient's Legal Guardian ☐ Patient's Health Care Proxy ☐ Other (specify)_____

(you will be required to provide legal documentation as proof of guardianship or health care proxy)

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Request A Patient Care Report

Federal and state law strictly limits who may obtain your confidential patient care report.

Patients

If you wish to request your patient care report, please download and print this form, complete it, sign it, and either send it as a scanned document via email or mail it (recommended via certified mail). Addresses are detailed below. The authorization form ***must*** be signed by the patient unless the patient is not capable of signing or is deceased. Should the patient be incapable of signing the authorization on his/her own behalf, the form may be signed by a Guardian or Health Care Proxy. Proof of Durable Power of Attorney that includes the power to make health care decisions (Health Care Proxy) or proof of guardianship is required for verification. In the case of a patient that is deceased, the authorization may be signed by his/her spouse or other next of kin or his/her executor.

Attorneys

Private attorneys seeking patient run reports in conjunction with litigation must submit a request in writing, on company letterhead, which must include the following information: incident date, incident location, approximate time of incident, and patient's name. A signed "Authorization for Release of Protected Health Information" must be attached to the request letter.

Law Enforcement

Please contact us to discuss the circumstances under which we can release a patient care report to law enforcement.

Addresses to send forms:

to send electronically please scan documents to PDF and email to:
chief@washingtonambulance.org please cc: assistantchief@washingtonambulance.org

to send copies via mail (certified mail or method with delivery confirmation is recommended):
Washington Ambulance Association, Inc.
Attn: Chief of Operations
P.O. Box 294
Washington Depot, CT 06794