

## **AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize Eagle County Health Service District A/K/A Eagle County Paramedic Service to release medical information from the medical records of:

Patient Name:			
Date of Birth:	Social Security (last 4 di	igits only)	:
Patient Street Address:			
City:	State:		Zip Code:
Date of Treatment Requested:			
Information to be disclosed:			
O Medical Records (Patient Care	e Record)		
O Billing Records The information may be disclosed to	: Name:		
	Address:		
	City:	_ State: _	Zip Code:
	Email Address:		
concerning drug related conditions, alcoholi disease, which are subject to federal and/or the information is not a health care provider may be re-disclosed and no longer protected	e medical record released pursuant to this authors, psychological conditions, psychiatric condinents at the restrictions on disclosure. I understand to ror health plan covered by federal privacy regulations. I hereby affirm that I hat the medical record for the purpose and extensions.	itions, and/ that if the pulations, the ave read and	or blood borne infectious erson or entity that receives e information described above d fully understand the above
Signature of Patient	Date of Signatur	 re	

Please email this completed form to: <a href="mailto:records@ecparamedics.com">records@ecparamedics.com</a>