711 East Orange Street
Shippensburg, PA 17257

SHIPPENSBURG AREA 73 EMS

717-532-6069
www.sa-ems.org

sa-ems.org

Patient Name_____ Date of Birth_____

Last 4 of SS#_____ Phone Number_____

Address_____

I authorize the use/disclosure of the following health information be released to:

Name_____

Address_____

Phone_____

Fax_____

Patient Care Report for What Date of Service_____

Purpose of Discolsure_____

I understand that the records for care, treatment or medical services provided to me, and retained by you, may contain information regarding my specific medical diagnosis, infectious diseases and/or insurance and financial information.

I further understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law.

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

I understand that I will be charged a fee of $35.00 prior to the processing of the medical records.

I further agree not to sue or hold the provider of information, its employees or agents, responsible for any issues, claims or causes of action arising out of the release of information in conformance with the terms of this release.

My signature, or that of my representative acknowledges that I have received, read and understand the content of the authorization, and voluntarily consent to the release of the information.

Patient/Parent Signature_____ Patient/Parent Printed Name_____

Relationship to Patient_____ Reason Patient Cannot Sign (If Applicable)_____

Date_____

SA-EMS Representative_____

Please print and complete form and mail or email to billing@sa-ems.org along with valid photo ID and copy of Power of Attorney Paperwork (if Applicable)