PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

In consideration of services rendered by the Fishers Fire Department Emergency Medical Service, I authorize release of any medical information necessary to process this claim for Emergency Medical Services. I also request payment of government and / or medical benefits to be sent to the Fishers Fire Department Ambulance Division.

Copy of Driver's License:

Signature Of Patient:_____

Signature Of Parent, If Minor:_____

Date Of Birth:_____

Social Security No._____

Dated:_____

FISHERS FIRE DEPARTMENT

Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Last Date of Service: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies which you may have upon request.

To better allow us to process your request, please indicate the type of request you are making on this form: [check all that apply]

_____ Access to simply review my health information.

_____ Access to obtain copies of my health information.

_____ Access to review and potentially request amendment of my health information.

_____ Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

_____ Access to review and potentially request restrictions on the use and disclosure of my health information.

Signature _____ *Request Date* _____

FISHERS FIRE DEPARTMENT
Patient Accounting Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, and request an accounting of certain uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from ABC Ambulance. **NOTE: The Fishers Fire Department is not required to provide you with an accounting of uses and disclosures associated with your treatment and transport, or for billing, payment or health care operations.**

Signature _____ *Request Date* _____

List of Uses and Disclosures

Date of Disclosure	Name/Address of Recipient	Purpose and Brief Description of Disclosure	PHI Disclosed

[NOTE: We must account for disclosures (other than those for treatment, payment and operations) of PHI made not only by our ambulance service, but by our business associates. We must provide the accounting within 60 days of the request, with an extension of an additional 30 days if we describe the reason for the delay in writing.]