

Williamson County EMS

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by Williamson County EMS of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient (include date of service if known):

This information may be used or disclosed by Williamson County EMS and may be disclosed to:

I understand that I have the right to revoke this Authorization at any time, except to the extent that Williamson County EMS has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Williamson County EMS's HIPAA Compliance Officer:

Theresa Carter
PO Box 873
Georgetown, TX 78626

512-943-1264
theresiacarter@wilco.org

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Williamson County EMS to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Williamson County EMS for the following purpose(s):

The use or disclosure of the requested information will ___/will not___ result in direct or indirect remuneration to Williamson County EMS from a third party.

Williamson County EMS

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: _____ (date or event).

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____

Description of the authority of personal representative:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Before me, _____, Notary Public for the State of _____, on this day personally appeared _____, known to me (or proved to me on oath of _____ or through _____ (description of identity card or other document) .

To be the person whose name is subscribed to the foregoing instrument and acknowledged to be that he or she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this ____ day of _____, _____

Notary Signature