AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Patient Authorization Form)

TO: EMERGENCY MEDICAL SERVICES AUTHORITY
1417 North Lansing Avenue
Tulsa, OK 74106 Phone: (918) 596-3110

6205 S Sooner Rd
Oklahoma City, OK 73135-5607 Phone: (405) 297-7110

Patient's Name: _____ Birth Date: _____

Address: _____ Soc. Sec. # _____

City: _____ State: _____ Zip Code: _____

I request and authorize EMSA to use or disclose my protected health information, or PHI, as described below.

Information to Be Used or Disclosed - Related to Services That Occurred During:

From (date)_____ to (date)_____

Specific description of information to be used or disclosed:
☐ All medical records ☐ Itemized Statement ☐ All billing records
☐ Other (specify):_____

Person/Organization Authorized to Receive and/or Use Information:

_____
Name/Organization

_____
Mailing Address City, State, Zip Code

Purpose of the Authorization. Please state the purpose of the requested use or disclosure below. If you do not wish to state a purpose, please check the box, "At the request of the patient or patient's personal representative":
☐ Insurance ☐ Legal ☐ At the request of the patient or patient's personal representative
☐ Other, (specify):_____

Right to Revoke and Expiration Date. I understand that I have the right to revoke this Authorization at any time, except revocation will not apply to information already used or disclosed in reliance on this Authorization. To revoke this Authorization, I understand that I must do so by a written request to EMSA, ATTN: Health Information Management, 6205 S Sooner RD, Oklahoma City, OK 73135-5607; Phone (405)297-7110). Unless revoked, this Authorization will automatically expire one year from the date of signature unless otherwise indicated (specify other expiration date or event):_____

Redisclosure. I understand that the information used or disclosed pursuant to this Authorization may be subject to unauthorized redisclosure by the recipient and no longer protected by federal privacy laws. I release EMSA, their agents, and employees from any liability in connection with the use or disclosure of the requested information covered by this Authorization.

Cost. I understand a reasonable fee may be charged for making copies and postage as authorized by law, and I agree to be responsible to EMSA for such cost.

I understand that signing this Authorization is voluntary and that the recipient of the information may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this Authorization, except in accordance with federal privacy laws.

_____ _____
Signature of Patient (Personal Representative) Date

Authority to sign if not the Patient (specify):_____
(If you are signing as a power of attorney, legal guardian, executor, or administrator, etc., attach a copy of legal documentation which provides your authority to act as the patient's Personal Representative.)

For Internal EMSA Use Only:	Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature
Run #:_____	☐ Other
Received by:_____	(specify):_____
Release Date:_____	Verified by:_____

This Authorization cannot be used to disclose Psychotherapy Notes.