

CHESTER AMBULANCE SERVICE

PO Box 370
556 Elm Street
Chester, VT 05143

Protected Health Information Release Authorization

Full Name: _____ Date of Birth: _____

Chester Ambulance Service may release my protected health information as described below to (Entity)
_____ for the purpose of
_____.

___ A complete copy of my medical records.

___ Other _____
(Description of authorized release)

The dates of care are to include _____ through _____.

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that this authorization may be revoked at any time by writing Chester Ambulance Service at the above address. I also realize that a revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Chester Ambulance Service shall not condition treatment, payment or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that Chester Ambulance Service has the right to charge a fee to the party listed above as result of this authorization.
- This authorization will expire on _____.
(If no date or event is stated, expiration is six months from the date it was signed.)

(Date)

(Signature of individual or representative)

(Authority or relationship of representative)