OFFICE USE ONLY **Date:** _____

Received by: Mail Office Email Fax (circle one)

Incident #_____ **DOS:** _____

Check # _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: ____/____/_____ SSN: _____/_____/_____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I. I hereby authorize Greenville County EMS to use or disclose the following health information as indicated below: (CHECK ONE)

☐ -EMS patient care reports _____ (date) to (date) _____

☐ - EMS patient care reports and billing statements _____ (date) to (date) _____

☐ - Other: _____

Greenville County EMS may disclose the above information to the following recipient:

Name (or title) and organization _____Relationship to patient: _____

Email: _____Mailing Address: _____

City: _____ State: _____

Phone: _____

PURPOSE OF DISCLOSURE: ☐ Legal ☐ Insurance ☐ Workers Compensation ☐ Continuing Care ☐ Other: _____

II. My Rights- I understand that:

This authorization will expire fourteen days from the date this authorization was signed.

I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

The uses and disclosures already made based upon my original permission cannot be taken back.

It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

The information in the patient care report may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

By signing below, I understand that this consent is to include disclosure of:
a) Alcohol and/drug abuse record; b) Psychiatric records; c) Sexually transmitted disease information, and d) HIV/AIDS information.

A photocopy of this authorization is to be considered as valid as the original.

I may request a copy of this authorization after I have signed it.

In compliance with the South Carolina statute, I will pay a fee of $ 6.00. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Name of Patient or Authorized Representative: _____

Note: If the patient is a minor or unable to sign, an authorized personal representative may sign this form.
If the relationship/authority of signature is not that of the patient (Written proof may be requested):

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Personal Representative ☐ - Special Administrator ☐ - Other: _____

Mail completed form to Greenville County EMS at 301 University Ridge, Suite 1100, Greenville, SC 29601 or fax to 864-467-7187
If you need assistance completing the form or have any questions please contact us at 864-467-5644