CITY OF CHICAGO
DEPARTMENT OF REVENUE-EMS
121 N. LaSalle Street, Room 107A
Chicago, IL. 60602-1288
(312) 742-7065

AUTHORIZATION FOR RELEASE OF INFORMATION OF AMBULANCE CHARGES

For the Use and Disclosure of Protected Health Information

PLEASE PRINT

Patient's Information:

_____

Name

_____ _____

Current Address **Apt. No.**

_____ _____ _____

City **State** **Zip Code**

_____/_____/_____ _____-_____-_____ ____/_____/____

Date of Birth **Social Security Number** **Date of Service**

_____ _____ _____

Location of Incident **Name of Hospital** **Ambulance Number**

By signing this Authorization Form, I understand that I am giving my authorization to the City of Chicago, Department of Revenue- EMS to use and/or disclose my protected health information (PHI). **I specifically authorize the use and disclosure of PHI pertaining to an <u>invoice for Ambulance transport</u> to the following attorney:**

Name of Attorney: RECORD COPY SERVICES ON BEHALF OF
Street Address: 30 N LA SALLE ST S-1800
City, State and zip code: CHICAGO IL 60602
Telephone number: 312.726.6650

This authorization shall expire on the 180th day of signing or as otherwise specified below:
_____.

I may revoke this authorization at any time by notifying the City of Chicago in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed by the City of Chicago before the City received the written notice of revocation.

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the **Health Insurance Portability and Accountability Act.**

I understand that the City of Chicago, Department of Revenue may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. This authorization is voluntary and I may refuse to sign this form, but in doing so, information will not be released to the above stated attorney.

I understand that I have the right to be provided with a copy of this signed authorization form.

Subscribed and Sworn
This _____day, of
_____, 200___.

_____ _____

Patient's Signature (Legal Guardian) **Relationship to the Patient**

_____ _____ _____

Notary Seal **Print Name** **Date**

(APPROVED BY CITY OF CHICAGO DO NOT ALTER.) **DOR: Rev: 01/2006**

PDDL