



**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 invoice for Ambulance transport to the following attorney:**

Name of Attorney: _____
 Street Address: _____
 City, State and zip code: _____
 Telephone number: _____

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