FALLON SERVICE INC. PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH	PHONE NUMBER
STREET ADDRESS	EMAIL ADDRESS	
CITY	STATE	ZIP CODE

By signing this Authorization, I hereby direct the use or disclosure by Fallon Service Inc. of certain protected health information (PHI) pertaining to the patient listed above.
This Authorization concerns the following information about the patient:

This information may be used or disclosed by Fallon Service Inc. and may be disclosed to:

I understand that I have the right to revoke this Authorization at any time, except to the extent that Fallon Service Inc. has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to Fallon Service Inc.'s HIPAA Compliance Officer:

Christine Hamilton
Fallon Ambulance Service
111 Brook Road
Quincy, MA 02169
617.745.2115
chamilton@fallonambulance.com

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for Fallon Service Inc. to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Fallon Service Inc. for the following purpose(s):

The use or disclosure of the requested information will____/will not____result in direct or indirect remuneration to Fallon Service Inc. from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: ___________________________ (date or event).

Signature:____**Date:** _____________________

Personal Representative Information (if signer is different from patient):

Name: ____

Relationship to Patient: ____

(parent, legal guardian, etc.)