AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Medicount Management, Inc.
10361 Spartan Drive, Cincinnati, Ohio 45215
PHONE : **513-772-4465** FAX : 513-772-4465 Email : **ptrelations@medicount.com**

Recipient of the Information:
I authorize the Health Care Provider listed above to release the information described in this Authorization to:

❑ SELF **- Name:** _____**Phone**: _____ **Fax**: _____

Street Address: _____ **City/State/Zip**: _____

Email Address: _____

Purpose of Disclosure:
❑ At the request of the individual ❑ Other (please specify): _____
Type of Information to Be Disclosed:
X Billing and Ambulance Transport Records Date(s) of Treatment REQUIRED – _____

1. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations, including the HIPAA Privacy Standards.
2. I may revoke this Authorization at any time by notifying the Health Care Provider in writing. I understand that such revocation will not apply to any actions already taken in reliance on this Authorization prior to the date the revocation is received.
3. I understand that treatment, payment, enrollment, or eligibility for benefits from or by any party may not be conditioned upon my providing this Authorization.
4. This Authorization will expire seven (7) years from the date of signature, or upon the final resolution and closure of all claims, lawsuits, or settlements related to my care on the identified date(s) of service, whichever occurs later.
5. Acknowledgment Regarding Email Communication:
   If I have provided an email address above, I acknowledge that unless the email is encrypted or otherwise secured, there may be a risk that PHI could be accessed by unauthorized third parties during transmission.

PATIENT ACKNOWLEDGMENT
By signing below, I acknowledge that I have read and agree to the terms of this Authorization, including the expiration conditions.
Signature of Patient or Patient's Representative:

X_____ **Date:** _____

Printed Name of Patient's Representative (if applicable):

X_____

Relationship to Patient:
❑ Parent ❑ ***Legal Guardian** ❑ Other: _____

***Legal documentation of representative's authority must accompany this Authorization.**