

KAUKAUNA AMBULANCE SERVICE

**Authorization to Use and Disclose
Specific Protected Health Information**

By signing this Authorization, I hereby direct the use or disclosure by Kaukauna Ambulance Service of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:

This information may be used or disclosed by Kaukauna Ambulance Service and may be disclosed to: (List name, specific identification of the person(s) or class of persons to whom Kaukauna Ambulance Services may disclose the identified PHI.

I understand that I have the right to revoke this Authorization at any time except to the extent that Kaukauna Ambulance Service has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the Kaukauna Ambulance Service Privacy Officer:

Privacy Officer
Kaukauna Fire Department
201 W 2nd Street
P.O. Box 890
Kaukauna, WI 54130

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 Kaukauna Ambulance Service to use my protected health information for treatment, payment and health care 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 Kaukauna Ambulance Service for the following purpose(s):

The use or disclosure of the requested information will ___/will not ___ result in direct or indirect remuneration to Kaukauna Ambulance Service 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.

_____ [Name] _____ [Date]

_____ [Description of the authority of personal representative, if applicable]

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

Please return the completed form to:

Kaukauna Rescue Service
Attn: Medical Records
201 W 2nd Street
Kaukauna, WI 54130