

COOPERSTOWN MEDICAL TRANSPORT, INC.
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization is voluntary. This form is used to authorize Cooperstown Medical Transport, Inc. to disclose protected health information ("PHI") to a person or organization for purposes other than for payment, treatment, or our operations. You may also restrict our disclosure of PHI to a person or organization for any purpose. We may deny your request for restriction upon review.

Please review and complete the following information. All sections (1 - 6) must be completed or this form will be considered incomplete and returned to you. One authorization form can be used per designated person or organization. For any additional person or organization, please complete a separate form. Please copy this form as needed or it can be downloaded from our website <http://www.cmtambulance.com>.

1. THE INDIVIDUAL

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

2. PURPOSE OF THIS AUTHORIZATION: Please note, that by signing this form, you will authorize Cooperstown Medical Transport, Inc. to disclose your protected health information for the following purposes. **Please check one:**

- Any Purpose
- Specific medical condition or service date(s): _____
- Other (briefly describe): _____

3. PROTECTED HEALTH INFORMATION TO BE DISCLOSED: Please indicate the specific protected health information you authorize us to disclose for the purpose stated above. **Please check all that apply:**

- Account Information (e.g. status, type of service, diagnosis, provider, dates of services, etc.)
- Insurance Payor(s) Membership Information (e.g. coverage information, enrollment dates, eligibility, address, birth date, etc.)
- Insurance Payor(s) Benefit Information (e.g. benefits available, benefits used, contract limits, etc.)
- Medical Records (e.g. Pre-hospital Care Report, physician's orders, etc.)
- Other (briefly describe): _____
- Exclude the following information: _____

4. ENTITY AUTHORIZED TO RECEIVE: Please indicate the person or organization name and address to which you are authorizing Cooperstown Medical Transport, Inc. to disclose the protected information to, as described above:

Name/ Organization _____

Address _____

City _____ State _____ Zip: _____

Is this person or organization the subscriber's employer / group health plan administration? **Circle one:** Y N

5. EXPIRATION OF THIS AUTHORIZATION: This authorization will stay in effect until: **Please check one:**

- A written notice of termination is received by Cooperstown Medical Transport, Inc.
- ___/___/___ (Date)

6. SIGNATURE: This authorization is not valid without your signature.

I, *(please print name)* _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Cooperstown Medical Transport, Inc. may disclose to the person and/or organization named in this form the protected health information, as described in this form, for the purposes stated in this form. I understand that I may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: _____ Date: _____

If a personal representative, on behalf of the individual, signs this authorization, please complete the following:

Personal Representative's Name: *(please print)* _____ Description of Authority: _____

Personal Representative's Signature: _____ Date _____

A personal representative must provide legal proof of representation, e.g. power of attorney.

Upon completion, return this form to: In Person: 81 Averill Rd., Cooperstown, NY 13326 By Mail: PO Box 202, Cooperstown, NY 13326
PLEASE MAKE A COPY OF THIS COMPLETED AUTHORIZATION FORM FOR YOUR RECORDS BEFORE SUBMITTING.