Midwest Ambulance Service, Inc

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Release of Information Form

I understand that Midwest Ambulance Service has an obligation to keep my personal information, identifying information, and records confidential. I also understand that I can choose to allow Midwest Ambulance Service to release some of my personal information to certain individuals or agencies.

I, _____, authorize Midwest Ambulance Service to share the following specific information:

Whom I want to have my information:	Name: Specific Office at Agency: Address: Phone Number:

The information may be shared:

☐ by phone ☐ by fax ☐ by mail ☐ by e-mail* ☐ in person

** I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What information about me may be shared:	*(List as specifically as possible. For example, name, dates of service, any documents.)*
Why I want my information shared:	*(List as specifically as possible. For example, to receive benefits.)*

I understand:

☐ This authorization shall be in effect for one (1) year or for the following specified date: Month: _____ Day: _____ Year: _____.

☐ I understand that this authorization is voluntary, and I have the right to revoke this authorization, in writing, at any time.

☐ That Midwest Ambulance Service and I may not be able to control what happens to my information once it has been released to _____, and that the agency or person receiving my information may be required by law or practice to share it with others.

☐ My signature below authorizes Midwest Ambulance Service to release my information as indicated above.

Signed: _____ Date: _____