Caller Authorization | HIPAA Form

Completed form may be sent via Fax: 336.740.9773 or via e-mail: einfo@emsbilling.com

PATIENT'S INFORMATION

Full Name	Date of Birth
Address	Telephone Number
City, State and Zip Code	Run Number | EMS Company Name

AUTHORIZATION

I hereby authorize use or disclosure of protected health information about me as described. The following person/class of person/facility is authorized to use or disclose information and receive information about me over the phone and make any updates to my contact information:

His/Her/Its Name	Telephone Number
Address	Relationship to Patient
City, State and Zip Code	/ / Authorization Expiration Date

DISCLOSURE

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying EMS Management and Consultants in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Patient's Signature	Patient's DOB or Social Security Number	/ / Date Signed
Or, if applicable		
Guardian or Personal Representative of Patient's Estate Signature	Relationship to Patient	/ / Date Signed

EMS|MC
EMS MANAGEMENT & CONSULTANTS
RESULTS | SERVICE | COMMUNITY
PO Box 863 Lewisville, NC 27023-0863 |Customer Service: 800.814.5339