HIPAA COMPLIANCE MANUAL

Authorization to Disclose Protected Health Information (Form D)

I, the undersigned patient, or my Personal Representative, hereby authorize Aetna Ambulance Service, Inc. *or* Ambulance Service of Manchester LLC to use or disclose Protected Health Information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV-related information regarding:

Patient Information: ____
Name

__________________________ ☐ Received reports in person
Date of Birth

Information to be disclosed to: ____
Name

____
Address

____
City State Zip

__________________________ __________________________
Phone Number Fax Number

A - Date of treatment or medical transfer:____________________________________ OR

B - Disclose information from the following range of dates: _______________ to _______________.

The purpose of this disclosure is for the following reason (check):

___ Medical ___ Legal ___ Disability ___ Insurance ___ Patient Request ___ Other

This Authorization will be valid for a period of one year from the date below.

I understand that I may revoke this authorization at any time by notifying the Privacy Officer in writing, but if I do, it will not have any effect on procedures or actions that The Ambulance Service of Manchester Ambulance LLC, or Aetna Ambulance Service, Inc., took before receiving the revocation.

I understand that under applicable law the information disclosed under this Authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or medical transfer by either The Ambulance Service of Manchester Ambulance LLC, or Aetna Ambulance Service, Inc., is in no way conditioned on whether or not I sign this Authorization and that I may refuse to sign it and that I may inspect or copy the information to be used or disclosed.

____ ______________________________
Signature of Patient or Legal Representative Date

____
Printed Name of Patient or Legal Representative

If signed by the Personal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority (Check one):

___ Parent ___ Guardian ___ Conservator ___ Executor of Estate

___ Power of Attorney for Health Care Decisions Other ____

NOTICE

HIV-RELATED INFORMATION

In the event that information released constitutes confidential HIV-related information protected under Connecticut Law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

In the event that information released constitutes confidential psychiatric information protected under Connecticut Law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it, or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.