

**Catawba County Emergency Medical Services**  
**Authorization to Disclose Protected Health Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Medical Record # \_\_\_\_\_ Patient SSN \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize **CATAWBA COUNTY**  
(Patient or Personal Representative)

**EMERGENCY SERVICES** to disclose specific health information from the records of the above named patient to:

\_\_\_\_\_  
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): \_\_\_\_\_

Specific information to be disclosed: \_\_\_\_\_

I understand that this authorization will expire on the following date, event or condition: \_\_\_\_\_

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is invalid. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Signature of Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship/Authority)

NOTE: This Authorization was revoked on \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff Signature)

Catawba County Emergency Medical Services

REVOCACTION SECTION

I do hereby request that this Authorization to Disclose Health Information of \_\_\_\_\_ (Name of Patient)

signed by \_\_\_\_\_ on \_\_\_\_\_ (Enter Name of Person Who Signed Authorization) (Date)

be rescinded, effective \_\_\_\_\_. I understand that any action taken on this Authorization prior to the rescinded date is legal and binding. (Date)

\_\_\_\_\_  
(Signature of Patient) (Date) (Witness) (Date)

\_\_\_\_\_  
(Signature of Personal Representative)\*\*\* (Date)  
(Relationship/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this Authorization by \_\_\_\_\_ (Name of Patient or Personal Representative)

on \_\_\_\_\_. The patient or the personal representative has been informed that any (Date)

action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
(Staff Signature) (Date) (Witness) (Date)

\*\*\*\*\*

\*\*\*Fill out below if your are requesting the release and are not the Identified Patient(s)

\_\_\_\_\_ I certify that I am the legal guardian of the above Identified Patient and have attached the necessary documents to verify such.

\_\_\_\_\_ I certify that I am the Administrator/Administratrix of the estate of the above identified deceased Patient and have attached the necessary documents to verify such.

\_\_\_\_\_ I certify that I have a Power of Attorney for the above Identified Patient and have attached the necessary documents to verify such. (NOTE: These documents must specifically state the Power of Attorney covers medical and legal matters.)