HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Ambulette Service and Medical Supplies LLC

Template notice: This form is intended as a general HIPAA authorization template. Have qualified counsel review it for your services, workflow, and applicable federal and state law before use.

1. Individual Information

Patient/Member Full Name: _____
Date of Birth: _____ Telephone: _____
Address: _____
City/State/ZIP: _____

2. Authorization to Use or Disclose Information

I authorize the person(s) or organization(s) identified below to use or disclose my protected health information as described in this form.

Person(s) or organization(s) authorized to disclose:
Name/Organization: _____
Address: _____
Telephone/Fax: _____

Person(s) or organization(s) authorized to receive:
Ambulette Service and Medical Supplies LLC and its authorized workforce members involved in the stated purpose.
Business Address: _____
Telephone: _____ Fax/Secure Email: _____

3. Information Authorized

Check and describe only the information needed:
☐ Demographic and contact information
☐ Physician orders, prescriptions, and certificates of medical necessity
☐ Diagnoses and medical information relevant to transportation or supplied equipment
☐ Mobility, transfer, accessibility, and safety needs
☐ Appointment, pickup, destination, and scheduling information
☐ Insurance, eligibility, prior authorization, billing, and payment information
☐ Delivery, fitting, maintenance, and service records for medical supplies or equipment
☐ Other specific information: _____

Date(s) of service or records covered: From _____ To _____
Excluded unless separately and specifically authorized where required by law: psychotherapy notes; substance-use-disorder records protected by 42 C.F.R. Part 2; HIV/AIDS-related information; genetic information; and other specially protected records. Additional authorization language may be required under applicable law.

4. Purpose of Use or Disclosure

☐ At my request
☐ To coordinate and provide non-emergency medical transportation
☐ To furnish, deliver, fit, maintain, or bill for medical supplies or equipment
☐ To verify coverage, secure authorization, submit claims, or resolve payment matters
☐ Other: _____

5. Expiration

This authorization expires on the following date or upon the following event:
☐ Date: _____
☐ Event related to me or the purpose of this authorization: _____

_____

6. Your Rights and Important Notices

- **Right to revoke.** I may revoke this authorization at any time by sending a written revocation to: Privacy Officer, Ambulette Service and Medical Supplies LLC, at the business address or secure contact listed in Section 2. The revocation becomes effective when received and will not affect actions already taken in reliance on this authorization. Other legal exceptions may apply.
- **No conditioning.** Ambulette Service and Medical Supplies LLC generally will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, except where the HIPAA Privacy Rule permits such conditioning.
- **Redisclosure.** Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal HIPAA privacy rules. Other laws may continue to protect the information.
- **Copy.** I understand that I am entitled to a copy of this signed authorization.
- **Voluntary authorization.** I understand this authorization and sign it voluntarily.

7. Signature

Signature of Patient/Member: _____
Printed Name: _____ Date: _____

If signed by a personal representative:
Representative Signature: _____
Printed Name: _____ Date: _____
Relationship to Individual: _____
Description of Authority to Act: _____
Documentation of Authority Reviewed: ☐ Yes ☐ No ☐ Not Applicable

8. Interpreter or Witness, If Applicable

I certify that I accurately interpreted or witnessed the execution of this authorization.
Name: _____
Role/Language: _____
Signature: _____ Date: _____

For Company Use Only

Identity verified by: _____ Date: _____
Authorization received by: _____ Date: _____
Expiration entered: ☐ Yes Revocation received: ☐ No ☐ Yes, date: _____
Copy provided to individual: ☐ In person ☐ Mail ☐ Secure electronic delivery
Staff initials: _____ Related trip/order/account no.: _____