



Ennis Ambulance Service

P.O. Box 147
328 W. Main Street
Ennis, MT 59729
406-682-4287
406-682-5011 fax

"CARING FOR OUR NEIGHBORS"

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: H) _____ Phone: W) _____

Address: _____ City/State/Zip: _____

Calls Date(s): _____

Specific Information Requested: _____

RESTRICTIONS: Only medical records originated through Ennis Ambulance will be copied. This authorization is valid only for the release of medical information dated on this authorization.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Ennis Ambulance Billing Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ Date: _____

Signature of Patient / Parent / Guardian or Authorized Representative Date (Guardian or Authorized Representative must attach documentation of such status.)

Printed name of Authorized Representative

Relationship Capacity to patient

Address and telephone number of authorized representative

Please Note: Ennis Ambulance charges \$5.00 per record found and released