



WESTERN EAGLE COUNTY AMBULANCE DISTRICT

PO BOX 1809
EAGLE, CO 81631

P: 970-328-1130
F: 970-328-1132

Consent/Authorization to Release Health Information

PATIENT INFORMATION		PLEASE RETURN BY FAX TO 970-524-1771	
Patient's Last Name	First	Middle	DOB
INFORMATION			
<input type="checkbox"/> Consult	<input type="checkbox"/> Labs	<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Other as specified below:	
<input type="checkbox"/> Emergency Department Report	<input type="checkbox"/> MRI Report	_____	
<input type="checkbox"/> EKG Tracings	<input type="checkbox"/> Operative Report	_____	
<input type="checkbox"/> Graphic Record	<input type="checkbox"/> X-Ray Report	_____	
<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-Ray MRI	_____	
Date of Order:	Purpose of Release:		
This consent/authorization is to release health information from and to:			
Name		Phone Number	
Address	City	State	Zip Code
This consent/authorization will remain in effect			
<input type="checkbox"/> From the date it is signed out until: _____ <input type="checkbox"/> Until the following event occurs: _____			
<small>Note: IF neither of the above options is selected, this consent/authorization will remain in effect for 180 days from the date this it is signed.</small>			
I authorize my health information described above to be released to Western Eagle County Community Paramedic Program to send all copies of my health record back to the above named entity for the purpose of continuity of care and understand that:			
<ol style="list-style-type: none"> 1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows: 2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C.F.R parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. 3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer-at the address listed at the top left of this form-with a written revocation which will not be effective until received and approved by the Privacy Officer. 4. I may refuse to sign this Consent/Authorization and this refusal will not affect the Treatment Western Eagle County Community Paramedic Program provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party. 			
Signature of Patient/Parent of Legal Representative		Date	
If signed by Legal Representative, Legal Representative's authority to act on behalf of patient: Relationship to patient:			
For Office Use ONLY			
Date Information Released		Medical Record Number	
Information Release by:			