KOOTENAI COUNTY
EMS SYSTEM

KOOTENAI COUNTY EMS, COEUR D'ALENE, IDAHO
AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Full Name: _____ **Date of Birth:** _____

Patient Social Security Number: _____ **Patient Phone #:** _____

Patient Address: _____

Person or Business authorized to disclose protected health information:
Kootenai County Emergency Medical Services System, (KCEMSS), 4381 W. Seltice Way, Coeur d'Alene, ID 83814

Records May Be Released To:
His/Her/Entity Name: _____Phone #: _____

Address: _____

Description of Information to be disclosed from dates: _____**to**_____

☐ Ambulance Trip Report/Patient Care Record ☐ Ambulance Billing

Check boxes you wish to have EXCLUDED in the records released:

☐ Substance Abuse ☐ Psychiatric/Mental Health ☐ HIV Information

For Office Use Only

Incident #: _____

Initials: _____

The information will be used/disclosed for the following purposes (select one):

☐ Continuing Care ☐ Insurance Purposes ☐ Personal ☐ Legal Purposes ☐ Viewing

☐ Other (describe): _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, information described above may be re-disclosed and no longer protected by regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I have the right to revoke this Authorization at any time, except to the extent that KCEMSS has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to KCEMSS's Compliance Officer:

Tracy Abrahamson
4381 W. Seltice Way
Coeur d'Alene, ID 83814

208-930-4224
tracya@kcemss.org

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

This authorization will automatically expire six months from the date signed, or until the 3rd party payor claim is settled. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance. To revoke this authorization, I must submit my request in writing to the Medical Record Department.

Print Name of Person Signing: _____

Signed: _____Date: _____

If signed by other than patient, indicate relationship & see below: _____

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST RECORDS FOR THIS PATIENT?

☐ PARENT ☐ CONSERVATOR ☐ GUARDIAN

☐ EXECUTOR OF WILL ☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

Note: Attaching legal documentation is required to verify that you are the parent, conservator, guardian, executor of a decedent's will, or have medical decision-making authority for the individual.