

Bloomsburg Volunteer Ambulance Association  
307 East Second Street Bloomsburg PA. 17815



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# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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The purpose of this form is to authorize the release of protected information regarding healthcare information. BVAA is obligated to follow strict guidelines for verification to ensure proper authorization is obtained. An individual may request copies of their own records, and billing statements at no cost. Third Party requestors are subject to any fees associated with research, labor, postage and production allowed by law. If an individual is incapacitated, a requestor must provide proof of documentation that supports incapacitation, such as: Power or Attorney, Death Certificate, or court order granting authority over the affairs of the individual. All requestors shall provide government issued photo identification with this request form, must be a valid and not expired to be accepted. By signing below, you authorize the release of this protected information to the requestor.

Requestor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

EMS Encounter Date: \_\_\_\_\_ Run # (If Known): \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

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### OFFICIAL USE

Requestor Verifications: \_\_\_\_\_ Copy Attached: YES or NO.

Patient Status: \_\_\_\_\_ If incapacitated, how was it verified: \_\_\_\_\_

**Robert Bebout, Paramedic (Supervisor of Records and Monies)**