

**COMMUNITY EMERGENCY MEDICAL SERVICE  
AUTHORIZATION FOR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**BY SIGNING THIS FORM, YOU ARE AGREEING THAT COMMUNITY EMERGENCY MEDICAL SERVICE, INC. (CEMS) MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.**

Name of Patient: \_\_\_\_\_ Date of Birth of Patient: \_\_\_\_\_  
Address of Patient: \_\_\_\_\_  
Social Security Number \_\_\_\_\_ and/or Medical Record Number of Patient: \_\_\_\_\_

I am the Patient

I am the Personal Representative of the Patient, because (initial one):

\_\_\_\_ I am the patient's custodial parent. \*

\_\_\_\_ I am the patient's legal guardian. \*\*

\_\_\_\_ I am the patient's Patient Surrogate. All conditions necessary for making the Surrogate designation effective have occurred. \*\*

\_\_\_\_ The patient is deceased. I am the properly appointed executor or administrator of the estate.\*\*

\* Evidence of relationship may be required.

\*\* Photocopies of all relevant documents must be attached.

By signing this Authorization, I hereby request and authorize that CEMS, and its agents and employees, release the following Protected Health Information ("PHI") (initial one):

Specific PHI to be disclosed: ( ) Run Report ( ) Face Sheet ( ) Entire Record ( )  
Other: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Purpose or need for disclosure: LEGAL REVIEW

CEMS is authorized to Use or Disclose the PHI indicated above in the following manner:

**Use of PHI By CEMS**

\_\_\_\_ Use PHI for CEMS Marketing Purposes. Exceptions: \_\_\_\_\_

\_\_\_\_ Use PHI for Fundraising Purposes (Name & Address only). Exceptions: \_\_\_\_\_

\_\_\_\_ Use PHI for Other Purposes (describe): \_\_\_\_\_

**Disclosure of PHI By CEMS To Other Individuals or Entities**

Disclose To: Name: MINUTE MAN SERVICES

Organization: \_\_\_\_\_

Address: 3318 N MAIN

City/State/Zip: ROYAL OAK, MI 48073

This Authorization expires ninety (90) days from the date signed below unless otherwise specified: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Notarized signature may be required for  
Requests not made in person

Subscribed and Sworn Before me, This

Day of \_\_\_\_\_, A

Notary Public in and for \_\_\_\_\_ County,  
Michigan.

\_\_\_\_\_  
Signature, Notary Public

\_\_\_\_ (Initial) I have read the information about authorizations and understand that (a) I can revoke an authorization, with certain exceptions; (b) CEMS will still provide care to me even if I don't sign an authorization, unless special circumstances regarding research exist; and (c) once information is released outside CEMS and its agents, CEMS is not responsible for any further disclosure of the information.