



Authorization for the Use and Disclosure of Protected Health Information

Please send completed form to Acadian Companies
Attn: Medical Records
P.O. Box 98000
Lafayette, LA 70509-8000
Email: MedicalRecords@acadian.com

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ SS#: _____
Email: _____

INFORMATION TO BE RELEASED

Treatment Dates: _____ to _____

Types of Records: Patient Care Report Billing Statement Both Other _____

REASON FOR RELEASE OF INFORMATION

Medical Care Legal Insurance Personal Other _____

I hereby authorize **Acadian Ambulance Service, Inc. and/or its subsidiaries** to use or disclose my protected health information as described in this authorization to:

Name or Company: _____

Address: _____

City: _____ State _____ Zip Code: _____

Email: _____

Indicate preferred method of delivery

Mail Secure Email

_____(Initial) I acknowledge, and hereby consent to such, that the release information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand I may revoke this authorization at any time by requesting such of Acadian Ambulance Service, Inc. and/or its subsidiaries in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A copy of this authorization will stand as the original.

This authorization expires on the following date: ____/____/____

*If an expiration date is not specified this authorization will expire (12) months from the date on which it was signed.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Patients Legal Representative

Date

Printed Name of Patient or Patients Legal Representative

Representative's relationship to patient