ACADIAN STANDARD CONSENT FORM
TO RELEASE HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____

DOB: _____ *SSN:* _____

Address: _____

Email: _____

Fax: _____

Indicate preferred method of delivery: ☐ *Mail* ☐ *Fax* ☐ *Email*

INFORMATION TO BE RELEASED

Treatment Dates: _____ *to* _____

Types of Records:

☐ *Patient Care Report* ☐ *Billing Statement* ☐ *Both* ☐ *Other* _____

REASON FOR RELEASING INFORMATION

☐ *Medical Care* ☐ *Legal* ☐ *Insurance* ☐ *Personal* ☐ *Other* _____

ACKNOWLEDGEMENTS

_____ *Initials* — *I acknowledge, and hereby consent to such, that the release information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.*

_____ *Initials* — *A copy or facsimile of this authorization will stand as the original.*

I hereby authorize **Acadian Ambulance Service, Inc.** *to use or disclose the following protected health information from the medical records of the patient listed below. 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 the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contest ability period under applicable law.

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

SIGNATURE *(If not signed by patient, see instructions on back for additional documents that will be required)*

_____ *Signature of Patient or Legal Representative*

_____ *Date*

_____ *Printed name of patient or patient's representative*

_____ *Representative's relationship to patient or authority to act for patient*

Please return to:
Acadian Ambulance Service, Inc.
Attn: Medical Records
P.O. Box 98000
Lafayette, LA 70509-8000
Fax: (337) 521-3641
Email: MedicalRecords@acadian.com
Pursuant to HIPAA Private Rule §164.508 appointments

INSTRUCTIONS FOR
ACADIAN CONSENT FORM
TO RELEASE HEALTH INFORMATION

Our Consent Form has been designed to comply with requirements contained in the federal privacy regulations, known as HIPAA, concerning protected health information. The patient or the patient's personal representative must complete and sign the Authorization.

While we do not provide legal advice and individual situations vary, personal representatives may include a patient's parents, spouse or adult children, as well as individuals who hold a power of attorney or who are responsible for handling a patient's estate.

If anyone other than the patient signs this form, the person requesting the information must include a copy of the requestor's driver's license or other government issued identification along with documentation showing that they have legal authority to make health care decisions on behalf of the individual.

Examples of documentation granting legal authority to request health information:

If the patient is an adult or an emancipated minor:

- *Health Care Power of Attorney*
- *Court Appointed Legal Guardian*
- *General Power of Attorney or durable power of attorney that includes power to make health care decisions*

If the patient is a minor:

- *Parent: A copy of the requestor's driver's license or other government issued identification*
- *Other than parent: Legal document showing that requestor is legal guardian or acting in loco parentis*

If the patient is deceased:

- *an order from the court stating that you are the executor or administrator of the estate*
- *an affidavit of small succession stating that you are an heir*
- *If you are the surviving spouse or parents, a death certificate will be sufficient*
- *If you are a child of the deceased, a death certificate and a copy of your birth certificate*

Please send completed form to:

Acadian Ambulance Service, Inc.
Attn: Medical Records
P.O. Box 98000
Lafayette, LA 70509-8000
Fax: (337) 521-3641
Email: MedicalRecords@acadian.com

Information regarding billing inquiries should be directed to:

Acadian Ambulance Service, Inc.
Attn: Customer Billing
P.O. Box 98000
Lafayette, LA 70509-8000
Phone (800) 259-2222
Email: PatientInquiry@acadian.com