CITY OF CHICAGO
DEPARTMENT OF FINANCE – EMS
2 N LASALLE STREET, SUITE #1230
CHICAGO, IL 60602
(312) 745-7329

AUTHORIZATION FOR RELEASE OF INFORMATION OF AMBULANCE CHARGES

For the Use and Disclosure of Protected Health Information

Patient Information *(Please print)*:

_____
Name:

_____ _____ _____
Current Address: *Apt. No.:* *City, State and ZIP Code:*

_____ /_____ /_____ _____ _____ /_____ /_____
Date of Birth: *Name of Hospital:* *Date of Service:*

_____ _____ /_____ /_____
Location of Incident: *Expiration of Authorization:*

By signing this Authorization for Release of Information of Ambulance Charges ("Authorization for Release"), I understand that I am authorizing the City of Chicago, Department of Finance – EMS to use or disclose my Protected Health Information ("PHI") for purposes of complying with the Health Care Services Lien Act. I specifically authorize the use and disclosure of PHI pertaining to charges for ambulance transport by the Chicago Fire Department – Emergency Medical Service to the following attorney or alleged liable party:

Name of attorney or alleged liable party:
Street Address:
City, State, ZIP Code:
Phone number:
Claim or policy number:

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Street Address:
City, State, ZIP Code:
Phone number:
Claim or policy number:

Use space on back of form to list additional parties/claim numbers.

I may revoke this authorization at any time by notifying the Chicago Department of Finance – EMS in writing. However, I understand that such revocation will not have an impact on any information already used or disclosed by the Chicago Department of Finance – EMS before it received the written notice of revocation.

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the **Health Insurance Portability and Accountability Act ("HIPAA")**.

I understand that the City of Chicago, Department of Finance – EMS may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization for Release. Signing the Authorization for Release is voluntary and I may refuse to sign this document, but in doing so, information will not be released to the above stated attorney(s). I understand that I have the right to receive a copy of this signed Authorization for Release.

_____ _____
Patient Signature/ Personal Representative ***Date***

_____
Relationship to Patient (If Personal Representative)

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