MedFlight911 Air Ambulance Service
Toll-Free Calling (888) 359-1911
Int'l & Local Calling (623) 249-6760
Toll-Free Faxing (888) 571-3735
Int'l & Local Faxing (480) 247-5512

Authorization to Use or Disclose My Health Information

Patient Name:_____ DOB:_____ Effective Date:_____

I. My Authorization

You may use or disclose the following health care information (*please initial all that apply)

___ All my health information maintained by the above-named practice
(*please circle "include" or "exclude" for each of the following)

Include / Exclude My health information related to HIV/AIDS
Include / Exclude My health information related to alcohol abuse
Include / Exclude My health information related to drug abuse
Include / Exclude My health information related to psychological or psychiatric conditions, including psychotherapy notes

___ My health information relating to the following treatment or condition
___ My health information for the dates(s):
___ Other: History and Physical (H&P), Face sheet, Inpatient and outpatient medical notes and diagnostic testing.

You may disclose this health information to:

MedFlight911 Air Ambulance LLC and the Corporate Compliance Officer at 16772 W Bell Rd Suite 110-274, Surprise Arizona 85374

Reason(s) for this information: (*please check all that apply)

___ AT MY REQUEST
___ For marketing purposes only by MedFlight911
___ Other: (specify) _____

This authorization ends: (*please check one)

___ On (date) _____
___ When the following event occurs for a period of no greater than the time required to: (1) Perform the agreed upon services, and (2) MedFlight911's Air Ambulance LLC received full payment for services performed.

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form

- To take part in a research study OR
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are;

- Fill out a revocation form. The form is available from the office. OR,
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or Legally authorized individual signature Relationship Date