CITY OF CHARLESTON, WEST VIRGINIA
EMERGENCY MEDICAL SERVICES
HEALTHCARE AUTHORIZATION AND
PRIVACY PRACTICES ACKNOWLEDGMENT

The City of Charleston, West Virginia Emergency Medical Services' ("EMS") Notice of Privacy Practices ("Notice") provides information about how EMS may use and disclose protected health information about its patients. In seeking or continuing to obtain health care from EMS and its healthcare professionals, **I authorize EMS to use and disclose my protected health information obtained in the course of treatment by EMS or from other health care providers in the manner outlined in the Notice**. I authorize EMS to maintain my medical records and others information pertaining to my care. EMS agrees to take reasonable steps to protect the confidentiality of my protected health information.

I am aware I have the right to receive and review the Notice before signing this acknowledgment. I understand that in an emergency I may receive emergency medical services prior to receiving a copy of this Notice, in which case I will be provided with a copy of the Notice as soon as may be reasonably practicable. I also understand the terms of the Notice may change. If EMS changes its Notice, I may obtain a revised copy. I acknowledge that a copy of the Notice has been provided to me, that I understand the contents of the Notice and how it applies to EMS's patients, and that all of my questions regarding the contents of the Notice have been answered.

I authorize EMS to use and disclose my protected health information in order to provide or obtain treatment or related services for me. I authorize EMS to use and disclose my protected health information to other hospitals, facilities, physicians, including my primary care or referring physician or a physician or other provider which EMS may consult, in order to facilitate my care, to arrange transfers, or to provide alternative or continuing care following my transfer or discharge and in case of a medical emergency. I authorize EMS to submit claim(s) to designated health insurance carriers and third party payors, and their agents, whether private or governmental, for all services rendered by EMS healthcare professionals in order to collect claims for payment, and to other health care providers involved in the patient's care (including persons not employed by EMS). I authorize EMS to release all such information as necessary to designated health insurance carrier(s) and their agents. I also authorize, request and direct designated health insurance carriers and third party payors to issue payment directly to EMS for services rendered. Furthermore, such information may be released, under an obligation of confidentiality, to any outside entity which performs a review of records at EMS to assure compliance with applicable laws and accreditation requirements or to assure quality treatment. Such information may also be released to third-party payors, benefit administrators, and guarantors, as necessary for verification of benefits, to determine necessity and appropriateness of services, for authorization of services, to process claims for benefits, and/or at hearings or appeals.

I understand that EMS cannot guarantee that the disclosure of protected health information to third parties will not result in the re-disclosure of such information by the third party. I understand that all of my protected health information can be used or disclosed as a result of this authorization even if it relates to treatment for physical and/or emotional illness, drug and/or alcohol-related conditions, sexually transmitted disease, HIV, AIDS, or AIDS-related conditions. I also understand that EMS may make disclosures of my health information without additional authorization for, among other purposes, scheduled transports, emergent transports, when required by law, and for health oversight activities. I acknowledge that EMS has taken reasonable steps to keep my protected health information private to the extent possible, and I understand I may have to take further action to preserve the confidentiality of this information if it is disclosed to third parties under such circumstances.

I understand that I have a right to revoke this authorization or place restrictions upon further authorization at any time. I understand that if I revoke this authorization or place restrictions upon further authorization I must do so **in writing** and must present my written revocation to the Privacy Official at EMS. This authorization and acknowledgement shall remain in effect so long as I remain a patient of EMS and thereafter for those purposes outlined in the Notice related to my treatment unless I revoke this authorization in writing. I understand that I may refuse to sign this authorization, and that any refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility (unless I am receiving research-related treatment or unless I am receiving health care services for the of disclosing such information to a third party). I understand that the revocation will not apply to information that has already been released as a result of providing emergency medical

services to me or in response to this authorization. I permit a copy of this authorization to be used in place of the original and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying EMS of any pre-certifications, referrals or co-payments required by my insurance company.

____ ____________________________
Signature of Patient or Legal Representative Date

____ ____________________________
Patient Name If signed by Legal Representative, relationship to patient

EFFECTIVE DATE: APRIL 14, 2003

To be completed by Charleston EMS personnel(check all that apply):

________ The NPP was not provided to client prior to transportation due to **emergent circumstances**

________ The NPP was provided to client and **client signed** the Authorization and Acknowledgment form

________ The NPP was provided to client and **client refused to sign** the Authorization and Acknowledgment form

________ The NPP was provided to the client's **family member or other representative** ____________________prior to transportation; family member or representative **did/did not** sign Authorization and Acknowledgment form(circle one)

________ Client was provided a copy of the NPP after transport and **did/did not** sign Authorization and Acknowledgment form(circle one)

________ A **good faith effort** was made to provide client with the NPP and the Authorization and Acknowledgment form and EMS was unable to do so for the following reason:______________________________________

SIGNATURE OF EMS PERSONNEL

____
NAME

____
UNIT NUMBER

____
DATE

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