<u>Rules for Release of Information Records:</u>

(Updated 4/14/2023)

- ***Any requests for release of information to attorneys, law offices, patients or patient's families must be approved by the ambulance administrator before releasing the information.***
- Release of information to insurance companies can be released without administrator approval.
- Patient fills out Form 10 only.
- Requestor fills out Form 10 and Form 10.1 if not the patient. Form 10.1 is required if someone other than the patient is requesting the records.
- Reason for request of information is required.
- Supporting documentation is required such as birth certificate, death certificate, POA information, photo ID or driver's license of person requesting the records. If the form is faxed or emailed this will need to be included with the returned document.

Form 10: Patient Request for Release of Medical Information and Records
Yankton County EMS Release of Protected Health Information

The HIPAA Privacy Rules (federal regulations that became effective April 14th, 2003) provide important protection for health information including that your authorization is obtained in certain circumstances. The privacy rules apply to the use and disclosure of protected health information (PHI) by entities providing medical care and treatment.

INSTRUCTIONS: Fill out form completely and accurately. Be sure to sign this document along with a copy of any supporting documentation, i.e. photo identification (required), driver's license, birth certificate, power of attorney, and/or death certificate.

If not fully completed, this request will be denied.

______________________________	XXX-XX-________________
Patient's name	Social Security number (last 4 digits)
______________________________	______________________________
Street address	Date of birth
______________________________	______________________________
City/State/Zip	E-mail, if applicable
______________________________	______________________________
Telephone	Fax, if applicable

Request or Access to PHI:
Below, please describe the PHI that you are requesting access to, being as specific as possible. Specify dates of service and other details that will allow Yankton County EMS to accurately and completely fulfill your request.

Patient care report date(s) of service: ____

Specify how you would like us to provide access:

________ *Mail a copy of my PHI to the above address.*

________ *E-mail a copy of my PHI to:* ________________________________
I understand that the information will be sent via an unsecured email. Initial: __________

________ *Mail a copy of my PHI to the following party:*

Designated party: ______________________ *Attention:* ______________________

Address (City, State, Zip): ____

________ *Fax a copy of my PHI to the following fax number:* ______________________________

________ *I would like to inspect a copy of my PHI (at a convenient time during normal business hours)*

________ *I will pick up a copy of PHI in person at the Yankton County Ambulance office during business hours*

I understand that my personal health information may include medical records created or received by EMS personnel, including records regarding emergency medical care, non-emergency medical care, records from other agencies and medical care facilities, and billing information. I authorize the release of this information to the individual or organization listed above only under the conditions listed below.

If not revoked, this authorization is valid until it expires six months from the date signed below or until the following date: ______________________ (MM/DD/YYYY)

I understand that I may revoke this authorization at any time, but I must do so in writing and send it to the Yankton County EMS privacy officer. The revocation will not be effective to my information that Yankton County EMS has already disclosed. I understand that the information disclosed is subject to re-disclosure and will no longer be protected by the federal privacy rules; 45 C.F.R. parts 160 and 164.

I understand that I have the right to receive a copy of this authorization after it has been signed. A copy or fax of this authorization may be used in lieu of this original.

______________________________ ______________________
PATIENT SIGNATURE (or legal representative) Date

Rev 4/14/23

Form 10.1: Patient Request for Access to Protected Health Information

Requestor Information (if requestor is not the patient)

Name: ____

Relationship to Patient (parent, legal guardian, etc.): ______________________________

Street Address: ____

City: ____________________________State: ___________ Zip Code: _______________

Phone: _____________________________ Fax: _________________________________

Email: ____

Official Use:

Provided via: _____US Postal Service _____Emailed _____Faxed

Picked up by ____ Date: _____________________

Released by ____ Date: _____________________