## City Of Yuma Ambulance Service Authorization to Use and Disclose Specific Protected Health Information

By signing this Authorization, I hereby direct the use or disclosure by City of Yuma Ambulance Service of certain medical information pertaining to my health, my health care, or me.

This Authorization concerns the following medical information about me:			
This information may be used or disclosed by City of Yuma Ambulance Service and may be disclosed to:			
[LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU MAY MAKE THE REQUESTED USE/DISCLOSURE]			

I understand that I have the right to revoke this Authorization at any time except to the extent that City of Yuma Ambulance Service has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the City of Yuma Ambulance Service Privacy Officer:

City of Yuma Ambulance Service Attention: Privacy Officer P.O. Box 265 Yuma, CO 80759 970-848-0372

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for City of Yuma Ambulance Service to use my protected health information for treatment, payment and health care operations.

I understand that I have the ri that is to be used or disclosed as particles being requested by City Of Yuma purpose(s):	rt of this Authorization. T	he Authorization
The use or disclosure of the reresult in direct or indirect remunera from a third party.  I acknowledge that I have reathat I have the right to refuse to sign	ition to City Of Yuma Ami	bulance Service uthorization and
agree to its terms.		
	[Name]	[Date]
representative, if applicable]	[Description of the author	ority of personal
This authorization expires on:		(date or event).