



City of Santa Fe Fire Department

P.O. Box 909, 200 Murales Road · Santa Fe, New Mexico 87504
(505) 955-3110 · FAX (505) 955-3115

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize employees of the City of Santa Fe to disclose information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

This authorization is for the release of information of the day(s) I received ambulance service from the City of Santa Fe. This release is valid only for the date(s) of service(s) I indicated:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Information that I authorize to be disclosed:

____ Ambulance/EMS Service Report _____
check initials

____ Billing Sheet Invoice _____
check initials

____ Insurance Information _____
check initials

____ Other _____
check initials

This information is to be disclosed to:

(Name of Person or Organization that you want to receive this information.)

Address

Phone

The information is to be disclosed for the following purposes:

____ I want it disclosed

____ Other reason (please specify, e.g. legal) _____

