



**Thorne Ambulance Service**

**Corporate Headquarters**  
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Greenville, SC 29607

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### Medical Records Release – Authorized Form

#### Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Thorne Ambulance Service, LLC** to use and/or disclose certain protected health information (PHI) about me to \_\_\_\_\_.

This authorization permits **Thorne Ambulance Service, LLC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:  
(If disclosure is requested by the patient, purpose may be listed as, “at the request of the individual”)

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire forty-five (45) calendar days from the date this form is signed.

The practice will \_\_\_ will not \_\_\_ receive payment or other remuneration from a third-party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Thorne Ambulance Service, LLC**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

**THORNE AMBULANCE SERVICE, LLC  
ATTN: PRIVACY OFFICER  
301 HALTON ROAD, SUITE G  
GREENVILLE, SC 29607**

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient’s Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if Applicable

Patient/Guardian must be provided with a signed copy of this authorization form.

*Note: This document is a template only, it does not reflect the requirements of your state’s laws. You should consult with advisors (e.g.: your state or local medical or specialty society, or legal or other counsel) familiar with your state’s privacy laws prior to using this document.*