



Bangs Ambulance, Inc
 205 W Green St
 Ithaca, NY 14850-5421
 607-277-4911

Authorization for family and close friends
 To assist patients with healthcare and accounting
 And to use and disclose
 Protected Health Information (PHI)

Patient Name: _____ Phone: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Patient Date of Birth: _____ Account #: _____

By signing this authorization, I hereby direct Bangs Ambulance, Inc., upon request to disclose protected health information (PHI) and general information regarding my healthcare and account to the person(s) listed below to the extent necessary for him/her to assist me with understanding my healthcare and accounts with Bangs Ambulance.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand I have the right to revoke this authorization at any time, except to the extent that Bangs Ambulance has already acted in reliance of the authorization. To revoke this authorization, I understand that I must do so by written request to:

Bangs Ambulance, Inc.
Compliance Officer
 205 W Green St
 Ithaca, NY 14850-5421

Attach copy of photo identification

Patient Signature: _____ Date: _____

Patient Name Printed: _____