RED BARON AMBUCS
P.O. Box 2413
Salina, Kansas 67402-2413

Request for Assistance

Name:____

Address:____

City:_________________________ State:__________________ Zip Code:________________

Telephone Number (Home):____________ (Work):______________ (Cellular):______________

Date of Birth: ______________________ Social Security Number: __________________

TYPE OF ASSISTANCE REQUESTED:

____ ***Amtryke*** _____ ***Cash (Maximum $500.00 to be paid directly to provider)***

What Assistance is Requested:____

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Statement of Nature of Illness/Disability:____

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Name and Address of Primary Physician:____

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Release of Medical Information

1. PATIENT INFORMATION.

Name: ____________________________________

Address: __________________________

__________________________, Kansas ________

SSN: ___________________

Date of Birth: ___________________

2. AUTHORIZATION FOR RELEASE. I hereby authorize ______________________________(medical provider) of __________________________(organization), __________________________(city), ____________(state), to release, disclose, and deliver the medical information described below to:

Authorized Recipient:
Red Baron Chapter of National Ambucs, Inc.
P.O. Box 2413
Salina, Kansas 67402-2413

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of all medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS-related information, if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

I do not give permission for any other use or redisclosure of this information.

Dated: ______________ ____(patient)

4. VALIDITY. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Dated: ______________ ____(patient)