PennState Health
Milton S. Hershey Medical Center

AUTHORIZATION FOR BENEFIT ASSIGNMENT & INFORMATION RELEASE-AMBULANCE

I hereby assign any benefits payable to Milton S. Hershey Medical Center for providing medical ambulance services. I understand that I am responsible for any balance in excess of the benefits/contract payable by this plan.

Milton S. Hershey Medical Center may disclose information about me and the treatment I am receiving, including copies of my medical record for purposes of treatment, payment, and medical center operations as described in our Privacy Notice.

I acknowledge that I have been offered the Milton S. Hershey Medical Center Privacy Notice.

SIGNATURE SECTION:
ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

This Section is for **emergencies or non-emergencies.** The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark Date

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an ambulance crew member.

X _____
Witness Signature Date

_____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for **emergencies or non-emergencies.** Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.
☐ Rep. of provider or nonparticipating hospital (**only** if reasonable efforts were first made to obtain signature of one of the authorized signers listed above).

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____
Representative Signature Date/Time Printed Name of Representative

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** if **all** of the following are true: (1) the call is an **emergency** ambulance transport, (2) the pt was physically or mentally incapable of signing, **and** (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt at time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____
Signature of Crewmember Date/Time Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. ***My signature is not an acceptance of financial responsibility for the services rendered to this patient.***

X _____ _____
Signature of Receiving Facility Representative Date/Time Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of signed documentation from the receiving facility indicating that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility)
☐ Patient Medical Record
☐ Facility Face Sheet/Admissions Record
☐ Hospital Log or Other Similar Facility Record

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