

FIRST RESPONSE AMBULANCE

PCR# \_\_\_\_\_

### Assignment of Insurance Benefits

I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents, FIRST RESPONSE AMBULANCE , or any insurance company, any information needed to determine Medicare benefits or the benefits payable for related services or any other type of insurance claim, now or in the future. I permit a copy of this authorization to be used in place of the original, and request that payment available under any insurance be made directly to FIRST RESPONSE AMBULANCE (Parents sign for Minors).

**I acknowledge, that FIRST RESPONSE AMBULANCE has made available to me their Privacy Policy.**

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
(Signature of Patient, Relative or Guardian)

\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
(Social Security Number)

**Patient unable to sign due to the following reason:**

\_\_\_\_\_  
  
\_\_\_\_\_

**Signature of EMT**

\_\_\_\_\_