

**Mid-Michigan Special Operations Support Team
Individual Health Information:**

Name: _____

Date Of Birth _____

Home Address _____

Home Phone # _____

Emergency Contact:

1) Name _____ Relationship _____

Address _____

Phone # _____

2) Name _____ Relationship _____

Address _____

Phone # _____

Medical History:

Current Medication:

Allergies: (Drug/Food/Environmental)

Blood Type:

(Over)

Private Health Care Provider:

Phone #

Hospital Preference:

Other Pertinent Medical Information:

Mid-Michigan Special Operations Support (SOS) does **NOT transmit ANY healthcare information electronically**. Therefore, we do NOT qualify as a “covered entity” under the provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA or PL104-191). However, we do agree with protecting the absolute privacy of **ALL**, personal-private health information in our custody. We will use all means reasonable to protect this private health information.

I authorize the release of any and all medical information to any and all emergency responders and/or any person(s) legally designated by me. I understand that the emergency responders may disclose this information to others.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____