

Mecklenburg EMS Agency (MEDIC) - Authorization for Release of Health Information Form

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider; the released information may no longer be protected by federal privacy regulations once it is disclosed.

PURPOSE OF RELEASE: Ongoing Communication Copy of Record Legal or Insurance Review Authorized Representative's Request Other

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information: Facility/Practice Name: Mecklenburg EMS Agency Telephone #: 704-943-6000 Facility/Practice Address: 4425 Wilkinson Blvd, Charlotte, NC 2808 Fax #: 704-943-6001

DATES OF SERVICE, RANGE OF TIME OR EVENT(S): The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or event(s): From: (MM/DD/YY) To: (MM/DD/YY) This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

CHECK THE SPECIFIC INFORMATION TO BE RELEASED: All Records & Details Discharge Summary Lab/Pathology Reports Appointment Information Patient Care Report Medication Records Billing Information History & Physical CAD Report Consultation Report 911 Tapes Operative Report Physician's Orders Progress Notes Psychiatric Evaluation Radiology/Imaging Reports Test Results Other (Please Specify)

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED: Patient Name: Patient Address: Social Security #: Date of Birth: Medical Record/Chart #: Please provide phone numbers where you are authorizing MEDIC to leave patient information as described above: Home: Work: Cell:

RELEASE TO: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Table with 4 columns: Name, Address, Telephone/Fax #, Relationship

PATIENT'S RIGHTS AND SIGNATURE: I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

PRINT NAME (Patient/Authorized Representative): SIGNATURE: DATE: If Authorized Representative, please indicate relationship to patient: Spouse Parent Guardian Executor of Estate Power of Attorney

MINOR'S SIGNATURE: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of whom consented for treatment. NAME OF MINOR: SIGNATURE OF MINOR: DATE:

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? Yes No N/A

FOR MECKLENBURG EMS AGENCY USE ONLY: MEDIC EMPLOYEES PLEASE COMPLETE

Identification verified Copy of Authorization given to patient / Date of release: via Mail Fax Other Accepted - Released information as described above Partially Accepted - Describe patient information not released:



STATE OF: \_\_\_\_\_

COUNTY OF: \_\_\_\_\_

I, \_\_\_\_\_, Notary Public for said county and state, do hereby certify that \_\_\_\_\_ personally appeared before me and acknowledged that he/she is the \_\_\_\_\_, e.g., Patient, Parent/Guardian, Health Care Agency, Administrator of Deceased Patient's Estate execution of the foregoing instrument.

Witness my hand and seal this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(SEAL)

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_