MEDIC
Medical Excellence. Compassionate Care.

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

PURPOSE OF RELEASE:

❑Request of individual/personal rep ❑Continued patient care ❑Insurance ❑Legal purposes ❑ Other _____

RELEASE FROM:

MEDIC - Mecklenburg EMS Agency, 4425 Wilkinson Blvd, Charlotte, NC 28208
Email: Records@medic911.com, Phone: 704-943-6000, Fax: 704-943-6001

DATES OF TREATMENT FOR RECORDS TO BE RELEASED:

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:

❑ Patient Care Report ❑ Billing Information ❑ 911 Tapes ❑ Other (Please Specify) _____

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____Date of Birth: _____Social Security#_____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the associated risks.

RELEASE TO:

Name of Facility, Person, Company: _____Relationship:_____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____Fax_____

DELIVERY METHOD: ❑ Unsecured Email ❑Secure Email ❑ Fax ❑ US Mail

PATIENT'S RIGHTS: I understand

- I have a right to revoke this authorization at any time. This can be done by notifying Medic Records via mail to the above address, or email at Records@medic911.com
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Revocation will not apply to information that has already been released in response to this authorization.
- Authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I may request to inspect or obtain a copy of the information used or disclosed per MEDIC'S' Notice of Privacy Practices/Policy.

If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Release of requested records will be completed once proper documentation is received (pg. 2.).

Note the relationship/authority if signature is not that of the patient: ❑ Spouse❑ Parent of Minor Child ❑ Guardian
❑ Executor/Administer/Attorney in Fact ❑ Healthcare Power of Attorney ❑ Other_____

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____DATE: _____

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: _____SIGNATURE: _____ DATE: _____

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REQUESTOR REQUIRED DOCUMENTATION:

- **Spouse** – Healthcare Power of Attorney or Court-issued Letters of Administration & Death Certificate (if available) or This Form Notarized
- **Parent of Minor Child** –Birth Certificate or This Form Notarized
- **Guardian** – Court-issued Guardianship Papers or This Form Notarized
- **Executor/Administrator/Attorney in Fact** – Court-issued Letters of Administration & Death Certificate (if available) or This Form Notarized
- **Patient's Healthcare Power of Attorney** – Copy of Healthcare Power of Attorney

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

(*You MUST indicate which applies*) –

1. Spouse 2. Patient 3. Guardian 4. Executor/Administrator/Attorney in Fact

for _____, (patient).

Witness my hand and seal this _____ day of _____, 20_____.

_____
Notary Public
My Commission Expires: _____

(SEAL)

_____