Authorization for Release of Medical Records

PURPOSE OF RELEASE: ❑Request of individual/personal rep ❑Continued patient care ❑Insurance ❑Legal ❑ 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 SERVICE TO BE RELEASE: (MM/DD/YY) From:______________________To: __________________
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.

INFORMATION TO BE RELEASED: ❑ Patient Care Report ❑ Billing ❑ 911 Tapes ❑ Other (Specify)____________

PATIENT INFORMATION: Name: _____________________________________ Date of Birth: ____________

Last 4 of SSN_______ Street Address: ___________________________ City, State, Zip: ____________________________

Telephone:_____________________ Email Address: _____________________________

RELEASE TO: Name of Facility, Person, or Company: ____

Street Address: _________________________________ City, State, Zip: _____________________________________

Telephone:___________________ Email Address: ____________________________ Fax:____________________

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

By choosing unsecured email as delivery method, you acknowledge and accept the associated risks.

- To revoke this authorization, notify Medic Records via mail to the above address or email at Records@medic911.com.
- Revocation will not apply to information that has already been released in response to this authorization.

If the requestor is other than the patient, release of requested records will not be processed without proper documentation, i.e., Court Order, Legal Documentation, Healthcare Power of Attorney, etc.

Requestor if other than the patient: ❑ Spouse ❑ Parent of Minor Child ❑ Guardian ❑ Executor/Administer/Attorney in Fact ❑ Healthcare Power of Attorney ❑ Other._______________________

PRINT NAME OF REQUESTOR: ____

PATIENT SIGNATURE: ____ DATE: _______________

REQUESTOR SIGNATURE (if not the patient): ___________________________________ DATE: ________________

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.

In-Person Release Information: ❑Photo ID or DL Verified ❑Required Documentation Provided

Employee Name: _________________________________ Date_____________________

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REQUESTOR REQUIRED DOCUMENTATION:

- **Spouse/Next of Kin** – Healthcare Power of Attorney, Court-issued Letter of Administration, or This Form Notarized
- **Parent of Minor Child** – Photo ID or This Form Notarized
- **Guardian** – Court-issued Guardianship Papers or This Form Notarized
- **Executor/Administrator/Attorney in Fact** – Court-issued Letters of Administration, or This Form Notarized
- **Patient's Healthcare Power of Attorney** – Copy of Healthcare Power of Attorney or This Form Notarized

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/Next of Kin
2. Parent of Minor Child
3. Guardian
4. Executor/Administrator/Attorney in Fact
5. Healthcare Power of Attorney

for ____________________________________, (patient).

Witness my hand and seal this ______day of _______________________, 20_____.

(SEAL)

____
Notary Public
My Commission Expires: ________________

March 2024