

Authorization for Release of Medical Records

Purpose of Release:

☐ Legal ☐ Other (please specify): _____

Release From:

MEDIC – Mecklenburg EMS Agency, 4425 Wilkinson Blvd, Charlotte, NC 28208

Dates of Service Requested (MM/DD/YY):

From: _____ To: _____

If exact dates are unknown, approximate dates are acceptable.

This authorization will expire once the requested health information (as indicated below), for the date(s) listed above, has been released to the recipient named in this document and the stated purpose of the release has been fulfilled.

Information to Be Released:

This authorization is valid only for the items selected below. A new request is required for any additional information.

☐ Patient Care Report and Associated Billing ☐ Billing Information Only ☐ Patient Care Report Only
☐ Other (please specify): _____

Release To (Law Office or Authorized Recipient):

Name of Law Office: _____ Street Address: _____

City, State, Zip: _____ Telephone: _____

Email Address: _____ Fax: _____

Delivery Method:

☐ Electronic ☐ In-Person Pick-Up ☐ Fax ☐ U.S. Mail

Email delivery may occur via secure/encrypted email when applicable.

Revocation of Authorization:

To revoke this authorization, notify MEDIC Records by mail at the address above or via email at Records@medic911.com.

Revocation will not apply to information that has already been released under this authorization.

Patient Information:

Patient Name: _____ Date of Birth: _____

Last 4 digits of SSN (optional): _____ Street Address: _____

City, State, Zip: _____ Telephone: _____

Email Address: _____

Patient Signature: _____ **Date:** _____

Authorization for Release of Medical Records

Authorized Representative (Non-Patient Requestor):

☐ Spouse ☐ Parent of Minor Child ☐ Legal Guardian ☐ Executor/Administrator/Attorney-in-Fact
☐ Healthcare Power of Attorney ☐ Other: _____

Documentation of authority may be required.

Name of Requestor: _____

Signature of Requestor: _____ Date: _____

Law Office Attestation (Required for Attorney Requests):

Release of records will not be processed until appropriate legal documentation such as a Court Order, written authorization, Healthcare Power of Attorney, or other required legal authority has been provided **or** until this attestation is completed by the receiving law office.

By signing below, the law office affirms that it has verified the identity of the patient requesting their own records **or** confirmed the legal authority of the requester, including parent of a minor child, legal guardian, executor or administrator of the patient's estate, Healthcare Power of Attorney, or Attorney-in-Fact.

Printed Name: _____

Signature: _____ Date: _____