CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the USE & DISCLOSURE of any and all medical records of:

Printed Patient's Name:_____ Phone: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Patient's Birthdate _____ Social Security Number: _____

Person/Organization Authorized to Release the Information:	Person/Organization Authorized to Receive Information:
Ultra EMS	**Self**

Date of Ultra EMS Transport: _____

Please provide me a copy of: (check all that apply)
- ☐ Medical Records
- ☐ Billing Records

For the purpose of: (optional)
- ☐ Further Medical Care
- ☐ Insurance Billing
- ☐ Legal Reasons
- ☐ Self
- ☐ Other (please specify):

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed **under this authorization**.

I understand that Ultra EMS must have an original signature on file; therefore, faxed record requests are not accepted nor will Ultra EMS fax records.

This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

_____ Date: _____

Signature

_____

Relationship to patient if patient is not signing

Note: If other than legal guardian **you must include** a letter of authority stating that the requestor is the Executor and/or Administrator of the patient's estate or Power of Attorney.

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. ***This authorization will expire automatically one year from the date on which it is signed***. Cancellation of this authorization prior to the limit must be made in writing and sent to:

Ultra EMS
Attn: Medical Records
PO Box 1242
Powell, OH 43065

- ✓ Please mail this completed form to the address above with a check for $25.00 made payable to: Ultra EMS
- ✓ Please be sure the name and address are clearly spelled out in the Person/Authorization to Receive Information section to ensure the medical records get to the correct person.