AUTHORIZATION FOR RELEASE OF EMS MEDICAL RECORDS

Patient Name: _____ Birth Date: _____

Social Security No: _____ Patient No: _____

Address: _____ Phone No: _____

___ I hereby authorize the above referenced entity to release my records to the following recipient for the purposes of my continued care.
___ I hereby authorize the above referenced entity to release my records directly to me so that I may hand-deliver them to the following recipient for purposes of my continued care:
Recipient Name: _____ Phone No: _____

Address: _____

Date of service needed: _____

I understand that this authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any records already released under this authorization. I understand that I am under no obligation to sign this authorization, and that my ability to obtain treatment from Liberty Ambulance will not depend in any way on whether I sign this authorization. I understand that I have a right to receive a copy of this authorization.

I understand that State and Federal law may prohibit the recipient from re-disclosing records provided pursuant to this authorization but that Liberty Ambulance has no control over the recipient and cannot therefore guarantee that the recipient will not re-disclose such records. By signing below, I authorize Liberty Ambulance to release records as described above.

Signature of patient: _____ Date: _____

If (i) the patient is a minor, the patient's parent or guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

Signature of representative: _____ Date: _____

Name of representative: _____ Phone No: _____

Relation to patient: _____

Employee releasing records: _____ Date released: _____