

# Protection-1 EMS | Request for the Release of Medical Records



- I am requesting review of my records
- I authorize the release of my records to a third party

## Where are the records being released from?

Provider Name(s):
Address:

## Tell us about the patient:

Name:	DOB: ___ / ___ / _____	SSN: ___ - ___ - _____
Email:		
Address:		
City:	State:	Zip:
Phone#:	Fax#:	

## Where are we sending the records?

Name:		
Email:		
Address:		
City:	State:	Zip:
Phone#:	Fax#:	

## What would you like released? (Check all that apply)

- Patient Care Report       Billing Records
- Dates \_\_\_\_\_ to \_\_\_\_\_
- Other \_\_\_\_\_

## Purpose of Disclosure: (Why are we sending the records?)

- Personal Use    Litigation/Legal    Insurance    Continuation of Care

## Delivery Method: (How would you like the records sent?)

- Email    Fax    Pick-up at Station    Postage (fees may apply)

**Patient's Signature**

I hereby authorize Protection-1 EMS and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, which I understand may include specially protected information such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_