Run #:_____

MEDICAL RECORDS RELEASE

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 CFR, parts 160, 164. Except as otherwise permitted or required by the privacy law, health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 CFR, 164.508(c).

Patient Name: _____ Date of Birth: _____/_____/_____

Last 4 Digits of Social Security Number: XXX-XX-_____

I hereby authorize Johnston County Emergency Medical Services to use or disclose the following Protected Health Information:

_____

_____

_____

I, _____ am requesting a copy of the medical records for:
(Name of Person Requesting Records)

_____, who was transported by ambulance on
(Patient's Name)

_____.
(Date of Transport)

I have read this authorization and I understand I have the right to refuse to sign it. I understand and agree to the terms of this authorization.

_____(Patient/Guardian Signature)

_____ (Relationship to Patient)

_____(Address)

_____

_____ (Valid ID #)

_____(Date)

_____

JC EMS Representative Signature