AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____ ____________________
Print Patient's Full Name Patient's Date of Birth

Records to be released from:

CITY OF MORAINE CLERK OF COUNCIL
MORAINE, OHIO 45439
937-535-1005 (PH) 937-535-1275 (FAX)

Records to be released to:

____
____
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Release the following information regarding my:

Emergency care on: ______________________________ (Specify date(s) of emergency care and/or transport)

Incident address: ____

Information requested: (All requests for billing information should be directed to Change Health Care (855)626-9660

☐ EMS Run (electronic) ☐ Fire Report (electronic version)

Requested Method of Disclosure:

☐ For pick-up on _________________ ☐ Postal Mail ☐ Other ________________________

☐ Fax ______________________________ ☐ Email ____
(Immediate patient needs only)

I HAVE READ REQUIREMENTS OUTLINED IN THIS FORM. IF THIS FORM IS NOT SIGNED IN FRONT OF THE CLERK OF COUNCIL WITH IDENTIFICATION BEING VERIFIED, THIS FORM MUST BE NOTARIZED PER OUR HIPAA POLICY.

____ ____________________________ _________
Patient's Printed Full Name Signature of Patient Date

Driver's License #:______________________________

____________________________ _________
Witness Signature Date

NOTARY STAMP AND SIGNATURE HERE

IF PATIENT IS A MINOR CHILD OR UNDER SOMEONE'S CARE, A COPY OF THE PATIENT'S BIRTH CERTIFICATE OR POWER OF ATTORNEY AND DRIVER'S LICENSE OF PARENT/GUARDIAN SHOWING RELATIONSHIP IS REQUIRED AND THE SIGNATURE MUST BE NOTARIZED.

____ __________________________________ _________
Print Full Name of Responsible Party Signature of Responsible Party Date

Driver's License #:______________________________

Relationship (Parent/Guardian/Power of Attorney) Specify: ____

THIS AUTHORIZATION MAY BE REVOKED UPON WRITTEN NOTICE TO THE CLERK OF COUNCIL. SINCE INFORMATION DISCLOSED IN RELIANCE UPON THIS AUTHORIZATION IS SUBJECT TO RE-DISCLOSURE BY RECIPIENT, THE CITY OF MORAINE OR THE MORAINE FIRE DIVISION HAS NO FURTHER RESPONSIBILITY TO INSURE THAT THE RECIPIENT MAINTAINS THE CONFIDENTIALITY OF SUCH DISCLOSED INFORMATION.

Check one of the following and complete as needed:

☐This Authorization expires on _______________ ☐This Authorization has no expiration date.