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:

MedCare

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Person/Organization Authorized to Receive Information:

Self

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Date of MedCare 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 MedCare must have an original signature on file; therefore, faxed record requests are not accepted nor will MedCare 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:

MedCare
Attn: Medical Records
2827 W. Dublin-Granville Rd
Columbus, OH 43235

Form: Medical Records
Reviewed: 02/26/21
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