

# Sumner Emergency Medical Services, Inc.

901 West First Street - Post Office Box 911 - Sumner, IA 50674

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving notification to and under conditions established by Sumner Emergency Medical Services, Inc. In support of your privacy, Sumner Emergency Medical Services, Inc. will not accept your blanket authorization of health information for treatment not yet received. A new authorization will be required for each subsequent incident. ***Make certain all blanks are filled. Failure to do so may result in the prevention, or delay, of the release of information.***

### Patient Identification (Person whose health information you want released)

Patient Name \_\_\_\_\_

Other Names, AKA \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Parents / Legal Representative \_\_\_\_\_

### Requestor Information (Person or entity you want to receive the health information)

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

### Information Requested (What health information do you want to have released)

Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_ Check the health information items you want released in regards to this incident:

☐ Electronic Patient Care Report ☐ ECG / Monitoring Recordings ☐ Advance Beneficiary Notice ☐ Physician Certification of Medical Necessity

☐ Billing Authorization and Privacy Acknowledgement ☐ Transport Refusal / Waiver of Liability

☐ Other (describe) \_\_\_\_\_

***I understand my health care and payment for my health care will not be affected by this authorization.***

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_

### SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol and drug abuse records or by state law for mental health records, federal and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. I specifically authorize the release of health information relating to: ☐ Substance Abuse ☐ Mental Health ☐ HIV / AIDS

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_

### Disposition

Disclosed: ☐ Yes ☐ No Date Disclosed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Director \_\_\_\_\_

***Iowa's First Rural Paramedic Service***

***Proudly Serving Sumner and the Surrounding Area Since 1982***