AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Address:_____

Information requested:

[] Pre-Hospital Patient Care Report for Run # _____ for service date on _____/_____/_____

[] Billing Statement for Run # _____ for service date on _____/_____/_____

[] WLAD Patient Signature Form for Run # _____ for service date on _____/_____/_____

[] Other (please specify)_____

Release information to: [] Myself (the patient or representative) [] to organization/individual below:

_____ _____
Organization Individual Name

_____ _____
Phone Address City State Zip

Purpose of Release: [] Medical [] Legal [] Insurance [] Personal [] Other:_____

I hereby authorize **Western Lane Ambulance District** to use or disclose the protected information from the records of the client listed above. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. ***I am aware that this consent is subject to revocation by me at any time unless action has been taken. This consent will expire six (6) months from the date it is signed.***

_____ _____
Signature of Patient or Legal Representative** Date

_____ _____
Printed name of Patient or Legal Representative Relationship or authority to act for patient

**Legal Representative – Document verifying as Legal Rep must be submitted with this request

For Office Use Only: Requested records were; [] picked up by patient [] mailed [] faxed #_____

Date:_____ ID verification: [] ODL_____ []copy attached

[] Legal Representative paperwork []copy attached

Records copy provided by WLAD Employee Signature: _____

WESTERN LANE AMBULANCE DISTRICT
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