



## 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:

Person/Organization Authorized to Receive Information:

MedFlight

Self

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

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