

Authorization to Release Copies of a Medical Record

Please complete this form in its entirety, so we can help you receive the information you are requesting.

1. This authorization is voluntary. I understand that Lifeguard Ambulance Service LLC will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document.

Patient Name: _____ Date of Birth: _____
 Street Address: _____ Social Security #: _____
 City, State, Zip: _____ Telephone: _____
 Email: _____ Fax: _____
 Select delivery method: US Mail Fax Pick Up Email (password protected)

2. I am the patient or the legal authorized representative of the patient listed above. I request Lifeguard Ambulance Service LLC to release my protected health information or the patient information listed above to:

Myself Other Person: _____
 _____ Company Organization: _____
 Street Address: _____ Telephone: _____
 City, State, Zip: _____ Fax: _____
 Email: _____

3. Purpose of release/disclosure to other person/organization:

Attorney/Legal Continuation/Transfer of Care Insurance Company
 Workman’s Compensation Other, specify: _____

4. Record set to be released to the party indicated above:

I request the following information be released, which may include: alcohol and drug abuse/treatment; psychological and social work counseling HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information for the purposes and conditions designated on this form.
 All clinical written or electronic patient care reports and anything on file from _____ to _____. This authorization expires on _____ (specify expiration date or event). *If the expiration date is left blank, the authorization expires 60 days from the signature date.*

5. Revoking/cancelling authorization: I may revoke/cancel this authorization at any time. Revocations/cancellations must be made in writing and sent to Lifeguard’s privacy department at the address listed on this form. Revocation/cancellation will not apply to information that has already been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy or the policy itself.

6. Note: once information has been disclosed, Lifeguard Ambulance Service can no longer protect it from further disclosure.

_____/_____/_____
 Signature of patient or legally authorized representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

 Print name of patient or legally authorized representative (if patient is a minor or unable to sign)
 Relationship to patient: Self Spouse Parent Next-of-Kin Legal Guardian
 Durable Power of Attorney for Healthcare

For Lifeguard Ambulance Service Use Only: Information: Mailed Picked Up Faxed Emailed
 Date Received: _____ Date Processed: _____ Processed By: _____

Additional Information Regarding Your Request

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON:

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a right to request the record set. Examples of these documents include letters of representation, guardianship papers, affidavits of heir at law, etc. Please contact the Privacy Department via phone at 866.333.1665 or email medrecords@lifeguardambulance.com to determine the documentation that will be required to process your request.

SUBMITTING REQUESTS AND RECEIVING RECORD COPIES:

Requests for medical records may be:

- Emailed to medrecords@lifeguardambulance.com
- Mailed to Lifeguard Ambulance Service, attn: Privacy Department P.O. Box 190007 Birmingham AL 35219
- Faxed to 205.380.2074
- Delivered to any Lifeguard Ambulance Service office. All delivered requests will be forwarded to and processed by the Privacy Department.

Records will be sent through US Mail, unless specified otherwise. Our average turnaround time for processing requests is fifteen (15) business days. Please include your phone number on your request, in case we need to contact you for additional information. For questions regarding requests for medical records copies, please contact the Privacy Department at 866.333.1665.