Authorization to Release Certain Records

****Please Note****

(1) Charges applied for request:
- **a. Search and Retrieval $29.61**
- **b. Pages 1-20 $2.00/page**

(2) Form MUST be COMPLETED and NOTARIZED by the PATIENT if the documents are being retrieved by someone other than the patient.

(3) PROPER Photo ID is required

(4) Form may be mailed or hand carried to:

South Central EMS
8065 Allentown Blvd.
Harrisburg, PA 17112

ADMINISTRATIVE USE ONLY:

Date of Request: _____
PCR #: _____
Copy of Photo ID (if not notarized): _____

Signature of person(s) Preparing Request: _____

Reviewed by Chief of Operations: _____

Date: _____

(Patient Information):

Legal Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

AUTHORIZATION TO RELEASE CERTAIN RECORDS

I, _____ hereby authorize **South Central Emergency Medical Services, Inc.** to release any medical record/patient care report related to the following date(s) of service:

Is Patient a Minor: ____ Yes ____ No

Date of Service: _____

Parent / Guardian Name: _____

This document authorizes South Central Emergency Medical Services Inc. to furnish records to:

_____

(Insert the name and address of the person or entity authorized to receive the protected health information)

This authorization extends to all records in the possession of the above-listed provider for the date specified above.

I agree to hold harmless the above-named medical provider and its agents from any actions and from all liability regarding the release of these records specifically.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer subject to protection under the law. I understand the confidentiality of this PHI is not waived for any other organizations, individual(s), Attorney or insurance company(s) not named herein. By affixing my signature below, I acknowledge that I release South Central EMS and its individual Departments, agents, and employees from any and all liability whatsoever in connection with this request to release medical records information. A photocopy of this release may be used in place of the original.

I understand that my records are or may be protected under the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Act (P.L. 92-282), the Pennsylvania Mental Health Procedures Act (1976), the Pennsylvania Confidentiality of HIV Act (35 Pa. C.S.A. §6301) *et. seq.* as well as the Health Insurance Privacy and Accountability Act otherwise known as H.I.P.A.A., and other various other protections including Attorney-Client Privilege, Physician-Patient Privilege, Counselor-Patient Privilege, and the Family Education Rights and Privacy Act otherwise known as F.E.R.P.A. and therefore could not be disclosed without my written consent.

****Extent of Authorization**

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the **EXCEPTION** of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

I intend this waiver to extend to the above-named, and to no one else. I reassert my rights to privacy and protection of these records absent the above exception to my attorney. I intend this authorizations and waiver of confidential information to be effective immediately and remain in full effect for one (1) year or the maximum amount of time allowable under the various statues or privileges, whichever of the two is shorter. I understand I have the right at any time, by written, dated communication to the above provider to revoke this authorization except to the extent that the action authorized has been taken in reliance of this document.

I agree to pay the reasonable cost of copying and mailing associated with this request.

SIGNATURE AND VERTIFICATION REQUIREMENTS:

Signature of Patient or Authorized Representative: _____

Date: _____

I am: ___ the patient

___ the parent of the patient, who is under 18 years of age

___ an authorized court-appointed representative of the patient

NOTARY USE ONLY

(If requestor is NOT the patient)

I so authorize this action.

This is a knowing, intelligent, and voluntary waiver which I wish to have fulfilled and honored immediately. The purpose for this release is specifically for _____

_____

_____

Executed this _____ day of _____ 20__.

_____

Patient Signature:

On this _____day of _____ 20__, having stood before me, the undersigned, appeared _____ **(Patient)**, proved to me through satisfactory evidence to be the person whose name and signature appears in the above-designated position, who swore or affirmed to me that the contents of the document were true, correct, and accurate to the best of his knowledge.

_____

My commission expires the ___ day of _____, 20__.