AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Patient's Date of Birth

Records to be released from:

MORAINE FIRE DEPARTMENT
MORAINE, OHIO 45439
937-535-1041 (PHONE OR FAX)
MGUADAGNO@MORAINEOH.ORG

Records to be released to:

_____
_____
_____

Release the following information regarding my:

Emergency care on: _____ (Specify date(s) of emergency care and/or transport)

Incident address: _____

Information requested:

All requests for billing information should be directed as follows:

- Change Health Care (855) 626-9660 ceteam@changehealthcare.com (records prior to January 2024)
- Medicount (513) 612-3154 mcollins@medicount.com (records January 2024 and after)

☐ EMS Patient Care Report (electronic) ☐ Fire Report (electronic)

Requested Method of Disclosure: (allow up to 30 days for processing)

☐ For pick-up on _____ ☐ Postal Mail (Must provide a self-addressed stamped envelope)

☐ Fax Currently unavailable ☐ Email Currently unavailable

Authorization:

Signature of Patient: _____ Date: _____

Signature of Personal Representative (if applicable): _____ Date: _____

Relationship of Personal Representative to Patient (personal representative shall show proof of authority to the disclosing entity)

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

Expiration of Authorization:

THIS AUTHORIZATION MAY BE REVOKED UPON WRITTEN NOTICE TO THE FIRE DEPARTMENT. SINCE INFORMATION DISCLOSED IN RELIANCE UPON THIS AUTHORIZATION IS SUBJECT TO RE-DISCLOSURE BY RECIPIENT, THE CITY OF MORAINE OR THE MORAINE FIRE DEPARTMENT HAS NO FURTHER RESPONSIBILITY TO ENSURE THAT THE RECIPIENT MAINTAINS THE CONFIDENTIALITY OF SUCH DISCLOSED INFORMATION.

☐ This Authorization expires on: _____ If no date is specified, this authorization will expire in one year from signing

For administrative use only:

Identity verification: ☐ Driver's License ☐ State ID ☐ Other Identification number: _____

Method of Delivery (paper, fax, electronic): _____ Date Released: _____