Perquimans County
Emergency Medical Services

159 Creek Drive – PO Box 563
Hertford, NC 27944
252-426-5646 Phone 252-426-1875 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPPA).

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization. Should you have questions about this authorization please contact the EMS Billing Office at (252) 426-5646.

Patient Information

Patient Name (first - middle - last):____

Incident Date:______________________________ Incident Number (if know):____________________

Incident Location:____

Requesting Parties Information

Name of Requestor:____________________________ Phone:______________________________

Company/Organization:__________________________ Email:______________________________

Address:____________________________________ Fax:________________________________

Relationship to Patient:

__Parent of Minor __Parent of Disabled Adult __Legal Guardian __Beneficiary __Spouse

__Patient Authorized Representative __Executor of Estate __Power of Attorney __Law Enforcement

You MUST provide a copy of the legal authority you have to make medical decisions for the patient listed on the medical report. If the patient is deceased a copy of the death certificate must be included with the request.

Format of Record Release

I request the record be released in the following manner:

__In Person __Mail __Email __Fax

OFFICIAL USE ONLY
Date Released:____________________
Staff Member:_____________________

Patient Authorization

By submitting this form, I hereby voluntarily authorize Perquimans County EMS to release this medical record. As the patient or the patient's representative, if I am authorizing the release of the medical record to a representative noted above. I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure. I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. I agree to hold harmless Perquimans County EMS from damages regarding the disclosure.

I hereby understand and agree that requests for electronic copies of my medical records from Perquimans County EMS in electronic form via email may not remain confidential due to the unsecure nature of email transmission. I further understand and agree that Perquimans County EMS, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system.

I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.

Patient Signature: ____ Date: ____________

Or, Signature from Other/ if NOT Patient: __________________________________Date: ______________

The following is required to be submitted with your request:

A copy of your Driver's License or DMV-Issued ID whether or not you are the patient.
Documentation of legal representation/responsibility if you are not the patient.