Medical Release Authorization

Name of Patient:_____

Date of Treatment: _____

☐ This will authorize any Medical Facility, and/or representative to procure from Cleveland County EMS **any and all medical records**, reports, histories, charts, and notes of any and every kind and description relative to my treatment, billing, care, and hospitalization.

☐ This will authorize my attorneys a the Law Firm of: _____ and/or representative to procure from Cleveland County EMS **any and all medical records**, reports, histories, charts, and notes of any and every kind and description relative to my treatment, billing, care, and hospitalization.

☐ This will authorize any Medical Facility, and/or representative to procure from Cleveland County EMS **any and all medical records** regarding AIDS/HIV information, reports, histories, charts, and notes of any and every kind and description relative to my treatment, billing, care, and hospitalization.

I have received a copy of Cleveland County EMS's Notice of Privacy Practices. Please initial here to document that you have received this pamphlet. _____

_____ _____

Medical Release Authorization patient/client signature **Date**

OR

I hereby certify that the above patient/client is unable to sign this medical release authorization due to being (circle one) a minor incompetent deceased and that I am duly qualified to sign this medical release authorization in that I am the _____ of said patient/client.

_____ _____

Parent/Guardian/Representative Date

Please sign and date below that you have verified the identity of the above-signed patient and or representative.