



**Medical Records Request, and,
Authorization to Use and Disclose Protected Health Information
(PHI) Form**

Instructions: Please Print Legibly, All Information/Blank Spaces Must Be Filled In For A Valid Authorization (Use N/A, If Appropriate).

In order to process a request, the completed and notarized form, along with a \$10.00 fee (cash, check, or money order), per patient/per date, must be submitted to:

Mountainair EMS
Mountainair Fire & Rescue Department
% Town of Mountainair
Attn: Medical Records
P.O. Box 115
Mountainair, NM 87036-0115

Check and Money Orders can be made payable to: Mountainair EMS

Requestor Information

Name of Requestor: _____

Relationship to Patient: _____

Company/Firm Name: _____
(If Requestor is an Attorney, otherwise use "N/A")

Requestor Address: _____

City: _____ State: _____ Zip Code: _____

Requestor's Phone Number: _____

Requestor's Signature: _____ Date: _____

By signing this Authorization, I, _____, hereby authorize the disclosure to the above Requestor by Mountainair EMS of certain medical information pertaining to the health care of:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth (D.O.B.): _____

Date of Service (D.O.S.): _____

Location of Service: _____

Relationship to Patient: _____

This Authorization is for the release of the following medical information about the above-named patient (check all that apply):

Patient Care Report (PCR - Run Report)

Billing Statement

Other:

(Must be specific)

This information is being used or disclosed for the following purpose(s):

(State specific purpose(s) or "By the request of the patient")

This Authorization shall be in force and effect until (specify date or event):

I understand that I have the right to revoke this Authorization at any time, except to the extent

that Mountainair EMS has already acted in reliance on the Authorization prior to the above expiration date or time, I understand that I must do so by written request to the Mountainair EMS, % Mountainair Fire & Rescue Department, % Town of Mountainair, HIPAA Compliance Officer at Mountainair EMS, Mountainair Fire & Rescue Department, % Town of Mountainair, P.O. Box 115, Mountainair, NM 87036-0115, phone number (575) 592-7067, or (505) 847-2321, or email to emschief@mountainairnm.gov, or townclerk@mountainairnm.gov.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law. I understand that this information may be hand-delivered, mailed, faxed, verbalized, or sent electronically in electronic form or format depending upon the circumstances of the request.

I understand that my written authorization is not required for Mountainair EMS to use my protected health information for treatment, payment, and health care operations. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.

I acknowledge that I have read the provisions in this Authorization and that I have the right to refuse to sign this Authorization. I acknowledge that I have read the Notice of Privacy Practices (separate provided document). I understand and agree to all terms.

***** IMPORTANT *****

The remainder of this form MUST be signed by the Patient, or, if a minor, his/her authorized parent and/or legal guardian, in the presence of a Notary Public.

Print Name: _____ Print Title: _____
(Patient or Parent/Legal Guardian) (or Relation)

Signature: _____ Date: _____

State of: _____

County of: _____

Subscribed to and sworn before me this _____ day of _____, 20_____

by _____.

Notary Public: _____

Signature: _____

My Commission Expires On: _____

Commission No.: _____