



Public Safety Department
EMS Billing
P. O. Box 1000
Bradenton, FL 34206-1000
Phone: (941) 749-3500
www.mymanatee.org

**PATIENT AUTHORIZATION TO RELEASE
MEDICAL RECORDS TO A THIRD PARTY**

Please provide the following information about the person ("Patient") whose records are requested to be disclosed:

Patient's Name:

Patient's birthdate: __/__/____

Patient's Driver's License or Identification Number: _____

Date(s) of Treatment: __/__/____ to __/__/____

Address of Incident: _____

I authorize Manatee County Emergency Medical Services ("MCEMS") to share the health information listed below with the following person(s), group or entity ("Agency"): _____

Agency Address:

Describe the medical records or type(s) of medical information MCEMS has the authority to disclose to the Agency identified above:

PURPOSE OF RELEASE (Check Reason):

Request of individual/Personal Rep.

Continuation of Care

Insurance

Attorney/Legal

Other:



FORMAT (Check Requested Method of Delivery): Electronic Paper copy

METHOD OF DELIVERY

Mail (insert address):

Pick Up

Fax: _____

Email: _____

This authorization for release of Patient's medical records covers the period of health care from ___/___/____ to ___/___/____.

This authorization for release of Patient's medical records shall be in force and effect until ___/___/____, at which time this authorization expires.

I understand that the information described above may be redisclosed by the person or group that I am giving MCEMS permission to disclose and therefore my information may no longer be protected by Federal privacy regulations.

I understand that I may revoke this authorization by submitting a Revocation of HIPAA Authorization Form to MCEMS with the understanding that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

Patient's
Signature _____

Date: ___/___/____

If the requestor of the Patient's medical records is a legal representative, guardian, health care surrogate or has the power of attorney, please provide the following information and review the back of this form for the required documentation proving your legal authority to request this information:

Name of Requestor: _____

Representative Capacity: _____

Requestor's Driver's License Number: _____

Address (if not the Patient):

Telephone (if not the Patient) _____

Instructions for Request for Medical Records:

A. If you are a legal representative of the person whose information you are requesting, you must provide the following documentation to prove your legal authority:

1. The records of a decedent - complete the information form on the reverse side. Provide a certified copy of the court order of your appointment as Personal Representative or Executor of the Estate, or a copy of the death certificate noting you as the next of kin or informant.
2. The records of an incompetent - complete the information form on the reverse side. Provide a certified copy of the court order of your appointment as Legal Guardian, Attorney ad Litem or Medical Power of Attorney.
3. The records of a minor - complete the information form on the reverse side. Provide a certified copy of the court order of Guardianship or a copy of a Birth Certificate showing you as natural parent of the minor.
4. Another person's records - complete the information form on the reverse side. Provide a notarized copy of general Power of Attorney or a Durable Power of Attorney for that person.
5. In all requests requiring a court document, the Clerk of the Court's file stamp and the stamped Official Book and Page number on the court order may be accepted in place of a certified copy.

B. Certain types of health information have specific laws and rules that must be followed before that information may be disclosed:

1. **HIV/AIDS and Sexually Transmitted Diseases (STD):** All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and Florida law and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving MCEMS permission to disclose. Redisclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission.
2. **Alcohol or Drug Treatment:** Alcohol and/or drug treatment records are protected under Federal and Florida law and regulations and cannot be disclosed without

your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving MCEMS permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Redisclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 C.F.R. Part 2).

3. **Mental Health Treatment:** Mental health treatment records are protected under Federal and Florida law and regulations and cannot be disclosed without the patient's or the patient's guardian written authorization unless otherwise allowed in Federal or Florida laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving MCEMS permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Redisclosure of your mental health treatment records is not allowed except in compliance with the law or with your written permission.

****All requests require your original signature and a clear photo ID of the requestor****

There is a \$5.00 pre-payment for each records request. Please send this payment either via check or money order made payable to Manatee County EMS to the address on the front. If desiring to pick up these records in person, please call (941) 744-3981 for further assistance.