

Authorization for Release of  
Medical Record Information



Call #:  
DOB:  
Pt Name:  
Gender:

To request release of medical information please complete and sign this form and return it to:

**North Jefferson County Ambulance District**  
**Attn: Medical Records**  
**2820 Horrell Lane**  
**High Ridge, MO 63049**

You may submit this form by Fax to: 314-472-0526

If you need help completing this form, please contact the Billing Department at 636-677-3399, Extension 26

Patient Information			
Patient Last Name	_____	First Name	_____ MI _____
Street Address	_____		Apt # _____
City	_____	State	_____ Zip _____
Patient Number#	_____	Home Telephone	( ) _____
Date of Birth	_____	Alternate Telephone	( ) _____
North Jefferson County Ambulance District has my permission to release information contained in the Medical Record of the above named patient.			
Information Requested (please be specific and enter date of service (if known):			
_____			
Restrictions and/or Exclusions (if any):			
_____			
Purpose of Release:			
North Jefferson County Ambulance District will provide the information requested above to the following party:			
Name	_____	Telephone	( ) _____
Attention of	_____	Suite/Room	_____
Street Address	_____		_____
City	_____	State	_____ Zip _____

I hereby authorize North Jefferson County Ambulance District to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that North Jefferson County Ambulance District cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at North Jefferson County Ambulance District may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that North Jefferson County Ambulance District has relied upon it. For example, if I cancel it after North Jefferson County Ambulance District has sent requested records, North Jefferson County Ambulance District will not retrieve those records. Instructions for canceling this authorization are included in the North Jefferson County Ambulance District Notice of Privacy Practices.

I understand that North Jefferson County Ambulance District will continue to provide care, even if I do not authorize this release.

Signature of Patient (if 18 years of age or older)	_____	Date _____
Signature of Parent or Guardian (if minor patient)	_____ Relationship to Patient _____	Date _____

**Please make a copy of this release for your records.**