Lakes Region

Authorization to Release Medical Records

Lakes Region EMS
40245 Fletcher Ave
North Branch, MN 55056
P: (651) 277-4911
F: (651) 674-4628

Call Number: _____
Patient Name:_____

Date of Birth: _____ Telephone Number: _____

Other Name(s) Used: _____

Address: _____

*This will authorize _____ to release and/or exchange medical information on the above listed patient to:

Name/Organization: _____

Street: _____

City: _____ State: _____ Zip Code _____

The following information is to be released (check appropriate boxes):

☐ Ambulance Report ☐ Ambulance Bill ☐ Other, Specify: _____

Release Information for the time period or condition (specify dates or condition):

_____

I am requesting this information for the use by (check appropriate boxes):

☐ Medical Personnel/Health Care Facility ☐ Insurance Company ☐ Personal Use

☐ Attorney/Legal Purposes ☐ Other, Please Specify: _____

- I understand there may be a retrieval and copy charge associated with the release.
- I do not authorize further release by the receiving requestor to any third party. I understand that once information is released pursuant to this authorization, the facility or physician named above, cannot prevent re-disclosure of that information.
- I understand I may revoke this consent at any time in writing, and that the consent will automatically expire one year from the date of my signature.

Signature of Patient: _____ Date:_____

Signature of Authorized Person: _____ Date:_____

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other, Specify: _____