Russell County Ambulance Service
108 Ferco Way
Jamestown, Kentucky 42629
Phone: 270-343-6464
Fax: 270-343-6462

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
Name of Patient (please print) Date of birth

_____ _____
Street Address, City, State, Zip Phone Number

_____
Maiden Name or other Name used for records

I hereby authorize: (Please Print) To Release to: (Please Print)

Russell County Ambulance Service

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

The following information from my records:

☐ Complete Health Record(s)_____

☐ Other (please specify) _____

Covering the period from _____to_____

I understand that this will include information relating to:
• Acquired Immunodeficiency Syndrome (Aids) or Human Immunodeficiency Syndrome (HIV) infection
• Psychiatric care
• Treatment for alcohol and/or drug abuse

If any, except as specifically stated here: _____

This information is to be disclosed for the purpose(s) of _____

Specify the date, extent or condition upon which this authorization expires_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Russell County Ambulance Service at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name of Patient's Representative

_____
Relationship to Patient

_____ _____
Signature of Witness Date

"Concern For Others"