Northern Dutchess Paramedics Inc.
P.O. Box 672, 3 Hook Road
Rhinebeck, NY 12572
(845) 876-3860 Fax: (845) 876-7071

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

All information must be completed in full

Patient Name: _____ Run Number: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request _____
(NAME OF MEDICAL SERVICE PROVIDER RELEASING INFORMATION)

_____
(ADDRESS OF MEDICAL SERVICE PROVIDER RELEASING INFORMATION)

to release to: _____
(**NAME OF PROVIDER OR INDIVIDUAL TO RECEIVE INFORMATION)**

_____
(ADDRESS OF RECEIVING PROVIDER OR INDIVIDUAL)

□ YES □ NO Medical information concerning the history, treatment, examinations. and/or hospitalizations for the periods from _____ to _____.
I understand this information will be used for _____

_____.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically in one (1) year from the date indicated below.

NOTE: Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the" written consent of the person to whom it pertains or is otherwise permitted by 42CFR,part 2.

Signature of Patient: _____ Date:_____

Witness: _____ Date: _____

_____ Date: _____
Signature Patient's Legal Representative

Relationship to Patient: _____

**** DRIVERS LICENSE MUST BE ATTACHED AS PROOF OF IDENTITY****