Red River Ambulance
PO Box 1020
Red River, NM 87558

Call Number _____

Authorization for Release of Protected Health Information (PHI)

Please complete, sign and return this form to: OR submit via fax to 575-754-6119 to:

Red River Fire Department
Patient Accounts
PO Box 1020
Red River, NM 87558

Patient Name _____ _____ _____
First M. Initial Last

Patient's Date of Birth _____ / _____ / _____ Date of Service _____ / _____ / _____

We have received your recent inquiry regarding a request for medicals records. The information below will allow us to legally expedite your request.

According to established legal requirements, as custodians of protected health information, we are unable to release any records without a signed, written authorization from the patient or his/her legal representative. To facilitate this process, please sign and return this letter confirming that you authorize a copy of the above medical record(s) for release. Please include a copy of the front and back of your driver's license or state identification.

If you are the patient's conservator, have medical power of attorney, or are his/her executor, please provide a copy of the supporting legal documentation. You must also include a copy of the patient's death certificate if applicable and a copy of your driver's license or state identification, so we can expedite your request. Records will be mailed to the patient's address only, unless noted otherwise by your legal documentation.

We will be glad to process your request, upon receipt of this signed release, accompanied by the required information listed above. If you have any further questions or concerns regarding this account, please contact our office at (575) 754-6568 and ask for ambulance patient accounts.

Signature _____ Date _____ / _____ / _____

Printed Name (If other than patient) _____

Relationship to patient: ❑ I am the patient, **or** _____

Driver's License/ID Number _____

Sincerely,

Red River Ambulance
Patient Accounts Department