18821 East Valley Highway, Kent, WA 98032
medicalrecords@trimedambulance.com
Phone: (888) 448-1232
Fax: (425) 454-0208

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize Tri-Med Ambulance, LLC to release medical records for:

_____ _____
Patient Name Date of Birth

Who Can Received My Health Information
I authorize the health information detailed below to be shared with the following individual(s) or organization(s).

Name / Organization: _____

Address / Phone: _____

Information to Be Released

- ☐ All healthcare information
- ☐ Specific healthcare information: _____

By initialing below, I specifically authorize the release of the following confidential information:

_____ Mental Health Records
_____ Communicable Diseases Including, but not limited to, HIV and AIDS
_____ Alcohol or Substance Abuse Treatment Records
_____ Reproductive Health Records

Form of Disclosure
I understand that receiving records through encrypted electronic means is generally considered the most secure method of releasing protected health information.

- ☐ Encrypted electronic copy via email (address): _____
- ☐ Unencrypted electronic copy via email (address): _____
- ☐ Hard (paper) copy or fax
- ☐ Other (specify): _____

Purpose of Disclosure

- ☐ Continuity of care
- ☐ Other (specify): _____

This authorization is valid for 90 days from the date of signature unless otherwise specified. I understand I am permitted to revoke this authorization by written notice to Tri-Med Ambulance at any time.

_____ _____
Signature of Patient or Legal Guardian Date of Signature

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient