TEAM MOBILE HEALTH CARE

Our Team is Your Team

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Release of Information to Team Mobile Health Care

(In compliance with HIPAA)

1. PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Address:		**Phone Number:**	
City, State, ZIP:		**Email (Optional):**	
Patient / Legal Representative:		**Relationship to Patient:**	

If you are not the patient, proof of legal authority may be required (e.g., Power of Attorney, Guardianship Documentation).

2. INFORMATION TO BE RELEASED

Please check all that apply:

- ☐ Medical Records *(Clinical information, history, treatment, etc.)*
- ☐ Transport Records *(EMT/EMS/Non-Emergency Transport Records)*
- ☐ Billing / Insurance Records *(Billing, insurance, and payment information)*
- ☐ Other (Please Specify): _____

Date(s) of Service: From: _____ To: _____ **Specific Information** *(If applicable)*: _____

3. RELEASE FROM AND TO

I hereby authorize the release of my protected health information as described above:

FROM (Release Information From)

Name of Facility / Organization:

Address:

City, State, ZIP:

Phone Number:

Fax Number (if known):

TO (Release Information To)

Team Mobile Health Care

355 Brogdon Rd Ste 107

Suwanee, GA 30024

Phone: 855-680-8326

Fax: (404) 635-2393

Email: accounting@teamambulance.com

Purpose of Release (Please check one):

☐ Continuity of Care ☐ Insurance / Billing ☐ Legal ☐ Personal Use ☐ Other (Please Specify): _____

I understand:

- This authorization is voluntary. I may refuse to sign this authorization.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- The information released may be redisclosed by the recipient and may no longer be protected by federal privacy laws.
- I may revoke this authorization at any time by written request, except to the extent action has already been taken.
- This authorization will expire one (1) year from the date signed unless otherwise specified below.

Expiration Date or Event (If other than one year): _____

4. AUTHORIZATION SIGNATURE

By signing below, I authorize the release of the information described in this form.

SIGN

_____ _____

Patient / Legal Representative Signature — Date Signed (mm/dd/yyyy)

_____ _____

Printed Name — Relationship to Patient (if not patient)

5. FOR OFFICE USE ONLY

Date Received: _____ Processed By: _____

Date Completed: _____

Method of Release:

☐ Mail ☐ Fax ☐ Email ☐ Other _____

Notes:

6. VERIFICATION / CONFIRMATION

Information released as authorized above.

_____ _____

Authorized TMHC Representative Signature — Date

7. HIPAA NOTICE

This information has been disclosed to you from records whose confidentiality is protected by federal law (HIPAA). The federal regulations prohibit you from making any further disclosure of this information without the **specific written consent** of the person to whom it pertains or as otherwise permitted by law.

POLICY REMINDER

- All released information must comply with HIPAA regulations.
- Only the minimum necessary information should be released.
- Retain this authorization in the patient record in accordance with TMHC policy.

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