



18821 East Valley Highway, Kent, WA 98032

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

**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. I understand I am permitted to revoke this authorization by written notice to Tri-Med Ambulance, LLC at any time.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient