Authorization for Release of Medical Record Information

North Jefferson County Ambulance District
Attn: Medical Records
3131 Rock Creek Rd, High Ridge, MO 63049

Please complete this form and email it to billing@njcad.com

Patient Information

Patient Last Name		**First Name**		**MI**	
Street Address				**Apt #**	
City		**State**		**Zip**	
Patient Number#		**Home Telephone**	( )		
Date of Birth		**Alternate Telephone**	( )		

North Jefferson County Ambulance District has my permission to release information contained in the Medical Record of the above named patient.

Information Requested (please be specific and enter date of service (if known):

PATIENT CARE REPORT

Restrictions and/or Exclusions (if any):

Purpose of Release:

North Jefferson County Ambulance District will provide the information requested above to the following party:

Name					
Attention of		**Telephone**	( )		
Street Address		**Suite/Room**			
City		**State**		**Zip**	

I hereby authorize North Jefferson County Ambulance District to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that North Jefferson County Ambulance District cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at North Jefferson County Ambulance District may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that North Jefferson County Ambulance District has relied upon it. For example, if I cancel it after North Jefferson County Ambulance District has sent requested records, North Jefferson County Ambulance District will not retrieve those records. Instructions for canceling this authorization are included in the North Jefferson County Ambulance District Notice of Privacy Practices.

I understand that North Jefferson County Ambulance District will continue to provide care, even if I do not authorize this release.

Signature of Patient (if 18 years of age or older)		**Date**
Signature of Parent or Guardian (if minor patient)	**Relationship to Patient**	**Date**

Please make a copy of this release for your records.