AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

The above person must indicate when this authorization is to expire:

☐ When information is received ☐ In one year

☐ On specified date: _____ / _____ / _____

(Release will expire in one year unless otherwise specified per Maryland Law)

The person named above has been a Patient of:

PLMD, LLC
d/b/a Pulse Medical Transportation
10715 Red Run Blvd, Suite 110
Owings Mills, Maryland 21117

The person named above hereby authorizes _____ **to**
Name of Person, Provider or Facility

☐ Request health information from PLMD, LLC ☐ Discuss Health Information with PLMD, LLC

The above person authorizes information to be requested or released by representatives of:

Name of Person, Provider or Facility Address: _____

_____

Phone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

SCOPE OF INFORMATION BEING REQUESTED:

☐ **All information regarding assessment, diagnosis and treatment of Patient's condition, concern or disease (specify):**

_____

☐ **All information regarding care received by Patient between the dates of:**

Starting Date: _____ **and Ending Date:** _____

☐ **Other, specify:**

_____

AUTHORIZATION:

Printed name of Patient or Authorized Representative: _____

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Signature of Witness **Date**

If not signed by the Patient, indicated relationship of authorizing person to Patient:

- ☐ Parent or Guardian of minor child
- ☐ Guardian, Spouse or conservator of conserved Patient
- ☐ POA, Beneficiary, Spouse or personal representative of a deceased Patient

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists or is included in Patients documentation, cannot and will not be released or discussed.

TREATMENT TYPE	INITIAL	DATE AUTHORIZED
Mental Health Treatment		
Alcohol or Drug Use/Abuse Treatment		
HIV Status or Treatment		

The above named person has the following rights:

- This Authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to Pulse Medical Transportation. Your revocation will be honored expect to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our HIPAA/NPP document – please reference on www.pulsemt.com or request from our billing department.
- The information you are requesting to be released could be released or disclosed by the recipient, such additional disclosures or released may not be prohibited by law. Pulse Medical Transportation is not responsible for the actions of others who may be provided with the information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will prevent Pulse Medical Transportation from sharing your information with the requestor named above.

PLEASE NOTE: Unless other specified by law, we will release only that information which has been created by our employees including chart notes, lab results, summaries and reports included in the Patient Care Report record. Reports or forms created by and available from other providers, hospitals or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying and sending of your records. If for personal use, you are entitled to ONE copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact Pulse Medical Transport for additional information regarding these fees.