Hart to Heart
TRANSPORTATION
////// The vital link in community health care //////

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Hart to Heart Transportation and/or Affiliates (H2H) **to release/receive** my medical record information including dates, history of illness, diagnostic and therapeutic treatment. The medical records to be **released/received** may contain medical information pertaining to transport and/or medical treatment.

Patient information:

_____
Last Name **First Name** **Middle Initial**

_____
Address **Apt. #**

_____
City **State** **Zip Code**

_____ _____ _____
Date of Birth **Social Security #** **Telephone #**

Please release records covering the time period for _____to _____

Information to be released:
( ) Complete copy ( ) Other _____

Purpose of disclosure: ( ) Continuum of Care ( ) Insurance ( ) Self ( ) other _____

**** Please note a fee may be charged for copies of the medical record. ****

Information to be released/sent to: (print name and address clearly) _____

_____

- I understand Hart to Heart may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- In addition, I authorize disclosure of medical records received from other providers. (Note: the disclosures of records furnished by other providers may be prohibited by those providers.)
- I understand this authorization shall expire in one year from the date noted below and can be revoked in writing at any time.. Such a revocation will not cover disclosures made previously in reliance on this authorization.
- Hart to Heart, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this authorization.
- I understand that the person/company receiving this information may not be subject to laws on confidentiality of medical information and may re-disclose it.

Signed: _____
(Patient or Representative) (Date)

If not signed by Patient; authority to act for minor or incompetent patient:
( ) Parent ( ) Guardian ( ) Power of Attorney ( ) Closest Family Member consenting for patient's care

Witness: _____