Members of EMERGENT HEALTH PARTNERS

HVA · JCA · MCA · LCA · ACA · LIFECARE AMBULANCE

Huron Valley Ambulance | Jackson Community Ambulance | Monroe Community Ambulance | Lenawee Community Ambulance | Albion Community Ambulance | LifeCare Ambulance

1200 State Circle Ann Arbor, MI 48108 | Phone: 734-477-6366 | Fax: 734-477-6776

MEDICAL RECORDS RELEASE INFORMATION

This document requires a NOTARIZED signature from the patient, legal guardian, or power of attorney to release medical records. Notarizations can be obtained at County Clerk offices, insurance companies, Credit Unions, or law offices.

Alternatively, the patient can request the records in-person at the Emergent Health Partners headquarters in Ann Arbor, MI. Photo ID is required for in-person records collection.

*A **notarized document** is a document that has been certified by a Notary Public. The **Notary Public** is an official who verifies the identity of individual signing a document, witnesses the signatures, and marks with the document with a seal.*

Obtaining Records

Patient: fill out the request authorization form complete with a notarized signature.

Minor child: along with notarized authorization form, a copy of the minor's birth certificate must be presented.

Legal guardian of patients 18+: if the patient is not their own legal guardian, along with a notarized authorization form, a copy of proof of power of attorney must be presented.

Deceased patient: along with notarized authorization form, a copy of the death certificate and proof of power of attorney must be presented. A valid photo ID matching the patient's name and date of birth on the death certificate will also suffice.

Please return completed authorization forms to:
Emergent Health Partners
Attn: Michelle Knott
1200 State Circle
Ann Arbor, MI 48108

If you would like to pick up records in person, please call to arrange a time:
Michelle Knott, Patient Accounts Representative
734-477-6366

All records requests submitted by mail will be processed within 30 days.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date of request: _____

Patient name: _____ Date of birth: _____

Date(s) of service: _____

Specific records for which access is requested: _____

_____

Requesting to:
__ See the records
__ Receive a copy of the records
__ See and receive a copy of the records

I, the undersigned, hereby authorize EMERGENT HEALTH PARTNERS to show or release protected health information (PHI) on the patient listed above to the following parties: _____

_____

By signing this document, I authorize a copy of this form to be used with the same effect as an original.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
For deceased patient: Personal Representative Signature Date

Mail or fax documents to:

Address: _____ City/State/Zip: _____

Fax #: _____ Contact Phone #: _____

THIS DOCUMENT MUST BE NOTARIZED

Notary Public - place seal in this area

Subscribed and sworn to me on: _____

_____ _____
Notary Public Signature Commission Expires