City of Cleveland
Department of Public Safety
Division of Emergency Medical Service

Medical Records Request and Authorization to Use and Disclose Protected Health Information (PHI) Form

Instructions: Complete this form and mail, along with a $5.00 fee (cash, check, or money order), per patient/per date of service to:

City of Cleveland
Department of Public Safety
Division of Emergency Medical Service
Attn: Medical Records Librarian
1701 Lakeside Ave
Cleveland, Ohio 44114-1118

(Make checks/money orders payable to: City of Cleveland – EMS)

REQUESTOR INFORMATION

Name of Requestor: _____

Firm Name (If the Requestor is an Attorney): _____

Relationship to Patient: _____

Requestor's Address: _____

City: _____ State: _____ Zip: _____

Requestor's Phone No: _____

Requestor's Signature: _____ Date: _____

PATIENT INFORMATION

Patient's Name: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Date of Service: _____

Location of Service: _____

Protected Health Information to be Released: Patient Care Report

This information is being used or disclosed for the following purpose(s):

This authorization shall be in force and effect until (specify date or event):

AUTHORIZATION BY PATIENT/LEGAL GUARDIAN

By signing this authorization, I, the undersigned, hereby authorize the disclosure to the above Requester by Cleveland Emergency Medical Service of certain medical information pertaining to my healthcare.

I understand that I have the right to revoke this authorization at any time, except to the extent that Cleveland Emergency Medical Service has already acted in reliance on the authorization prior to the above expiration date or time, I understand that I must do so by written request or via email to:

Cleveland Emergency Medical Service
Attn: Privacy Officer
1701 Lakeside Ave
Cleveland, Ohio 44114
Email: emsprivacyofficer@clevelandohio.gov

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law. I understand that this information may be hand-delivered, mailed, faxed, or verbalized, dependent upon the circumstances of the request.

I understand that my written authorization is not required for Cleveland Emergency Medical Service to use my protected health information for treatment, payment, and health care operations. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this authorization.

I acknowledge that I have read the provisions in this authorization and that I have the right to refuse to sign this authorization. I understand and agree to its terms.

Print Name of Patient or Legal Representative	Relationship to Patient
Signature of Patient or Legal Representative	Date