North Country EMS – Release of Information or Medical Records & Payment Authorization Form

Patient Name: _____ Transport Date: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to North Country EMS for any services provided to me by North Country EMS now, in the past, or in the future. I agree to immediately remit to North Country EMS any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to North Country EMS. I authorize North Country EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: By signing below, I hereby acknowledge that I have received North Country EMS' Notice of Privacy Practices.

SIGNATURE SECTION: ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE
This Section is for emergencies or non-emergencies. The patient must sign here unless the patient is physically or mentally incapable of signing. NOTE: If the patient is a minor, the parent or legal guardian should sign here.

X_____
Patient/Guardian Signature or Mark

Relationship _____
If the patient signs with an "X" or other mark, crew member must sign below as a witness.

X_____
Witness Signature

_____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE
Complete this section only if patient is physically or mentally incapable of signing.
Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include only the following individuals (check one):
☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative/other person who receives government benefits on behalf of patient
☐ Relative/other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency/ institution that furnished care, services or assistance to the patient.

X_____ _____
Representative Signature Printed Name of Representative

_____
Representative's Address

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES
Complete this section only if all of the following are true: (1) the call is an emergency or non-emergency ambulance transport, (2) the pt was physically or mentally incapable of signing, and (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt at time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf.

Reason patient incapable of signing: _____

X_____ _____
Signature of Crewmember Printed Name of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility at the date and time indicated above.

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X_____ _____
Signature of Receiving Facility Representative Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)
If no facility representative signature is obtained, the ambulance crew should attempt to obtain a hospital face sheet or other documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.