Authorization to Release Medical Information

Failure to provide all information may invalidate this authorization

Patient Information

Patient Name: _____ Reference Number: _____
(Last Name) (First Name)

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Company & Information to Release

Company: Please check the company from among those listed below.

- ☐ Rocky Mountain Holdings LLC
- ☐ Mercy Air Service, Inc.
- ☐ Lifenet, Inc. DBA Arch Air Medical Service
- ☐ Native American Air Ambulance, LLC
- ☐ CJ Critical Care Transportation Systems, Inc.
- ☐ Tri-State Care Flight, LLC

Date of Service:_____

Please check the box(es) that correspond with your desired information.

- ☐ Flight Medical Records
- ☐ Billing Records
- ☐ Other (Please Specify): _____

Release To

I authorize Air Methods Corporation and/or its known entities to Release Medical Records to:

Person / Organization: _____

Address: _____

City/State/Zip:_____

Phone: _____ Fax: _____

Air Methods Medical Records Department
PO Box 2532, Fontana, CA 92334
Fax: 402-952-2413

Delivery Instructions	☐ Mail records directly to person or organization specified ☐ Fax records when records are ready: I authorize Air Methods PBS to fax my records to (____) ____ - _____ ☐ Email: _____
Notice of Rights	I understand that: 1. If I refuse to sign this authorization my refusal will not affect my ability to receive treatment. 2. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **Air Methods PBS Medical Records Department, PO BOX 2532, Fontana, CA 92334.** 3. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 4. I have a right to receive a copy of this authorization. 5. The released information may be disclosed by the recipient and may no longer be protected by federal regulations. 6. Fees or charges will comply with applicable laws and regulations regarding the release of information.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____
Signature	Signature: _____ (Patient or Legal Representative) **If signed by legal representative please provide a copy of your court order paper work such as the Power of Attorney, Administrator of Estate or Death Certificate.** Date: _____ Relationship to Patient: _____ **PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE FOR PROOF OF IDENTITY.** Note: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.

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