



Charles County Government
 Department of Emergency Services
 Emergency Medical Services Division
 P.O. Box 2150
 200 Baltimore Street
 La Plata, Maryland 20646



Please complete the Release of Protected Health Information Form below by filling out any sections which apply to you. Failure to complete the proper sections, could result in a delay of accessing or releasing your requested information. Don't forget to sign the form. Please return this completed form to us as soon as possible. Thank You

RELEASE OF PROTECTED HEALTH INFORMATION FORM

I _____, hereby request the following information for:
 (Please Print Full Name)

Patient Full Name: _____ Account Number: _____

Patient Address: _____ Date of Birth: _____

_____ Soc. Sec. #: _____

Please indicate choice with an **X** in the appropriate box and complete any additional requested information.

To access, copy or inspect my Protected Health Information in possession of Charles County EMS. I understand if a copy of the information is requested that I may be charged a nominal fee to photo copy my information.

An accounting of disclosures of my Protected Health Information from _____ to _____ in possession of Charles County EMS
 (mm/dd/yyyy) (mm/dd/yyyy)

To amend written medical information in possession of Charles County EMS.
 (If additional space is needed, use additional paper to fully explain your request)

Information to amend: _____

Reasoning: _____

Signed X: _____ Relationship: _____ Date: _____

| | | |
|---------------------------|-----------------------------------|---------------------------------|
| FOR OFFICIAL USE ONLY: | <input type="checkbox"/> APPROVED | <input type="checkbox"/> DENIED |
| Reason: _____ | | |
| Official Signature: _____ | Title: _____ | Date: _____ |