



City of Rio Rancho
Department of Financial Services - Ambulance Billing
Authorization for Release of Medical Records

This form must be completed by the patient, a parent/guardian, or legal representative thereof. Complete all the information on the form. Please contact us at (505) 891-5021 with any questions.

Section I - Patient Information

Date of Birth: _____

Patient Name:

Last Name

First Name

MI

SSN: _____

Section II - Information Requested

I am requesting the following record(s) - Check applicable box(es):

checkbox

Protected Ambulance Billing Records

Rio Rancho Fire Rescue Patient Care Report (PCR)

Protected Health Records From (date): _____

To (date): _____

Patient Limits the Release of the Following Information:

Non-protected records may be obtained by filing a request with the City Clerk's Office.

Section III - Release The undersigned authorizes the City of Rio Rancho to release any and all medical records of treatment by the City of Rio Rancho to:

Name:

Last Name

First Name

Company: _____

Address:

Street

City/State

Zip

Phone #: _____

Fax #: _____

E-Mail: _____

By signing this authorization, I understand the following conditions apply: (1) I have the right to revoke this authorization by providing a written notice of revocation to the City of Rio Rancho - Department of Financial Services/Ambulance Billing. The revocation will not apply to information that has already been released prior to the receipt of the written revocation. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim. (2) The City of Rio Rancho will not condition treatment on whether I sign this authorization. (3) I have a right to inspect and receive a copy of the material to be disclosed. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy rules. (4) Authorizing the disclosure of this health information is voluntary and I may refuse to sign the authorization. (5) I have the right to request a copy of this authorization. (6) A copy of this authorization is as valid as the original.

Patient Signature: _____

(or legally authorized)

Date

Witnessed By: _____

Date

Please return this completed and signed form along with a copy of your ID to: Attn: Ambulance Billing, 3200 Civic Center Circle NE, Rio Rancho, NM 87144 - or fax to: (505) 891-5762