AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: MIDWEST MEDICAL TRANSPORT COMPANY, LLC

FAX: 402-625-0012

I Hereby request AND authorize that my medical records be released to:

Location: _____

Address: _____

Preferred method of Submission: _____

Date(s) of Records: _____

_____

Name (Print) Birth Date

_____

Address, City, State, Zip

SS# _____

Contact Phone #: _____

Signature of Patient/Parent/Legal Representative:

_____ _____

Date

_____

Printed Name of Representative & Relationship to Patient