CITY OF CLEVELAND
Mayor Frank G. Jackson

Emergency Medical Services Authorization for Release of Medical Billing Information

CITY OF CLEVELAND
DEPARTMENT OF FINANCE
Division of Assessments & Licenses
601 Lakeside Avenue, Room 127
Cleveland, Ohio 44114

Phone: 216.664.2598 8am to 5pm Weekdays

INCOMPLETE FORMS MAY BE REJECTED AND RETURNED TO THE REQUESTER

Patient Name: _____
(Please Print) Last First Middle

Date of Birth: _____ **SSN:** _____
(MM/DD/YYYY) (Full Number XXX-XX-XXX)

Address: _____
Street, City, State, ZIP

Phone: _____ **Treatment Date(s):** _____
(XXX) XXX-XXXX (MM/DD/YYYY)

RELEASE MEDICAL BILLING INFORMATION TO THE FOLLOWING RECIPIENT

Person/Organization: RECORDS DEPOSITION SERVICE, INC.
(Please Print)

Relationship to Patient: _____

Purpose: PRE TRIAL DISCOVERY

Address: PO BOX 5054, SOUTHFIELD, MI, 48086-5054
Street, City, State, ZIP

Phone: 248-357-3330
(XXX) XXX-XXXX

INSURANCE CLAIM INFORMATION – INCOMPLETE INFORMATION MAY DELAY YOUR REQUEST

Insurance Carrier: _____
(Please Print)

Claim No.: _____

Claim Type: ☐ Motor Vehicle Accident ☐ Property-Related Injury ☐ Other Personal Injury ☐ Sickness/Disease

Carrier Type: ☐ Liability ☐ Private Health ☐ Public Assistance (Medicare, Medicaid, disability) ☐ Worker's Comp

IMPORTANT - Insurance carriers are billed in order of payer priority. Payers of last resort shall not be billed before liability or private insurance carriers. Private insurance carriers shall not be billed before liability insurance carriers.

I hereby authorize the City of Cleveland to release the health information indicated above that is contained in my patient billing records to the Recipient named above. I understand and acknowledge that this may include billing information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS. This authorization does not include permission to release outpatient psychotherapy notes. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one (1) year from the date of authorization written below. I understand that the Recipient of my health information may be charged for the service of releasing medical billing information. Your health care will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

Signature: _____ **Date:** _____
Signature of Patient (MM/DD/YYYY)

Representative: _____ **Title:** _____
Signature of Authorized Representative Representative's Relationship to Patient

Rev. 7/2015