

## MEDIDRIVE LLC – HIPAA AUTHORIZATION FOR RELEASE OF TRANSPORTATION RECORDS

Member Name	Date of Birth	Member ID Number (If known)
Address		Phone Number

**I authorize MediDrive LLC to release the following information:**

- |                                                           |                                                                   |
|-----------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Transportation trip history      | <input type="checkbox"/> Pickup and drop-off locations            |
| <input type="checkbox"/> Dates of transportation services | <input type="checkbox"/> Transportation authorization information |
| <input type="checkbox"/> Transportation billing records   | <input type="checkbox"/> Other: _____                             |

This information may be released to:	
Name	Organization (if applicable)
Address	Phone/Email

Purpose of disclosure			
<input type="checkbox"/> Personal use	<input type="checkbox"/> Legal matter	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: _____

Expiration of Authorization	
<input type="checkbox"/> Date: _____	<input type="checkbox"/> Event: _____

If left blank, this authorization will expire one year from the date signed.

I understand that:

- I may revoke this authorization at any time in writing.
- Information released may no longer be protected by HIPAA if redisclosed by the recipient.

By signing below, I confirm that I understand this authorization and agree to the release of the information described in this form.

- I am the Member/Patient  
 I am signing as the Member's Personal Representative

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If Signed by Personal Representative**

Complete this section only if someone other than the member is signing.

**Relationship to Member:**

- Parent
- Legal Guardian
- Power of Attorney
- Caregiver
- Other: \_\_\_\_\_

**Authority to Act for the Member (check one):**

- Minor child
- Court-appointed guardian
- Healthcare power of attorney
- Other legal authority: \_\_\_\_\_

Representative Phone Number	Representative Address
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Email to [compliance@medidrive.com](mailto:compliance@medidrive.com). Please allow 5-10 business days for processing. Additional time may be required if identity verification or clarification of the request is needed.