

AFFIDAVIT FOR PRODUCTION OF INMATE RECORDS***All fields must be completed***(After completing this form, please email to medrecreg@r1rcm.com or fax to 385-215-7047)

Facility Name: _____ Date: ____/____/____

I, _____, a _____, _____, hereby certify:
(Print Name) (Title) (Badge or ID number if applicable)

1. I am an official representative of:

- ☐
- Correctional Facility, _____
-
- (Print Correctional Facility Name)

Mailing Address: _____ Phone: _____

- ☐
- Authorized law enforcement agency, _____
-
- (Print Authorized law enforcement agency name)

Mailing Address: _____ Phone: _____

2. The following patient is in our legal custody:

NAME: _____
DATE OF BIRTH: _____

3. I wish to:

- ☐
- Review records of this patient only
-
- ☐
- Obtain copies of the following records of this patient: _____
-
- ☐
- Email to: _____ Fax: _____
-
- ☐
- Other: _____

4. The records I am requesting are for the purpose of:

- ☐
- The provision of health care to the patient;
-
- ☐
- The payment of health care for the patient;
-
- ☐
- The health and safety of the patient or other inmates;
-
- ☐
- The health and safety of the officers or employees of or others at the correctional institution;
-
- ☐
- The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;
-
- ☐
- The administration and maintenance of the safety, security, and good order of the correctional institution.

5. If substance abuse records protected under federal law, 42.U.S.C. section 290dd-2, these records can only be released in a bona fide medical emergency without authorization by the patient or pursuant to a specific type of court order.

- ☐
- I hereby certify this is a medical emergency and the purpose of this disclosure is to provide health care to the patient.
-
- I will use these records for no other purpose.

Signature of Correctional Facility Representative: _____

Date: _____



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