East Dundee Fire Protection District

PATIENT RELEASE FORM

EMS Report Number:_____

Patient Name_____
LAST FIRST M.I.

Address_____

City_____ State_____ Zip_____ Day Phone#:_____

Birth date:_____S.S.#:_____ Evening Phone#:_____

I request and authorize _____ to disclose my health information to the following:

Name:_____

Address:_____ Suite_____

City:_____ State _____ Zip _____ Phone #:_____

I request and authorize the following dates of service to be disclosed: _____

The type of information to be disclosed is as follows:

☐ Ambulance/EMS Medical Reports ☐ Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information for which I am authorizing disclosure will be used for the following purpose: _____

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record department. I understand that the revocations will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

(Please insert a date or event) This authorization will expire on _____. If I fail to supply an expiration date or event, this authorization will expire in 90 days from the date it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature: _____ Date:_____

If signed by a legal representative, relationship to patient _____

Signature of witness: _____ Date:_____

If I can't personally pick records up you may release the copies to _____

☐ Copies made and given/sent with patient on _____ (date).