



Authorization for release of medical records

This Authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize Hillsboro Fire & Rescue to release a copy of the medical record obtained and/or recorded by their employees to the person identified below. I specifically authorize the release of information pertaining to drug or alcohol abuse, psychological or psychiatric conditions, and/or communicable disease information, if such are a part of the pre-hospital medical record. I agree to pay the \$20.00 fee associated with providing this record.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

Patient Name: (print) _____

Patient Date of Birth: _____ / _____ / _____ Incident No. _____

Location of incident: _____

Date of incident: _____

Purpose of Request: _____

Identification: Please include a copy of the requesting party's driver's license and other information as they apply.

- Driver's License SS Card Power of Attorney Passport Personal Representative Death Certificate Other

* * * * *

Please release to: (print) _____

Street/PO Box: _____

City/State/Zip: _____

Phone: _____

This Authorization may be revoked at any time. To revoke this Authorization, I understand that I must do so by written request to the Hillsboro Fire & Rescue at the address below. The only exception is when action has been taken in reliance on the Authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Date

Signature of Patient or Other Person Authorized to Sign for Patient

Relationship to Patient

Printed Name

FOR HILLSBORO FIRE AND RESCUE USE ONLY
Date received: Received by: Paid: Check #:
Approved by EMS office. Denied by EMS office. Reason for denial: Initials and Date:
Referred to: Date released: Released by: