REDMOND FIRE & RESCUE

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www.rdmfire.org

AUTHORIZATION TO RELEASE 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 Redmond 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, reproductive health information, and/or communicable disease information, if such are a part of the pre-hospital medical record. I understand this record may be voluminous and agree to pay all reasonable charges associated with providing this record.

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

PATIENT INFORMATION:

NAME (PRINT):_____

DATE OF BIRTH:_____ INCIDENT NUMBER:_____

RECIPIENT INFORMATION: (if you are requesting a copy of your own records, you are the recipient)

NAME:_____PHONE:_____

ADDRESS:_____

INFORMATION TO BE DISCLOSED:

- ☐ Entire Emergency Medical Services record.
- ☐ Records related to services provided on or between _____ and _____.
- ☐ Other (specify), _____

This Authorization may be revoked at any time. To revoke this Authorization, I understand that I must do so by written request to Redmond Fire & Rescue Medical Records at the address above. The only exception is when action has been taken in reliance on the Authorization. The revocation of this Authorization has no bearing on disclosures which have already occurred under this 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