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 Crooked River Ranch Fire & Rescue to release a copy of the medical records 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 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 redisclosure by the recipient and no longer subject to privacy protections provided by law.

Patient Name: (print) ____

Date of Birth: ___________/___________/___________ Incident No. ____

Purpose of Request: ____

IDENTIFICATION: _______Driver's License ________SS Card _________ Student ID ________Passport

________Personal Representative Other: ____

Please release to: (print) ____

Street/PO Box: ____

Phone: ____

This Authorization may revoked at any time. To revoke this Authorization, I understand that I must do so by written request to the Crooked River Ranch Fire & Rescue Records Custodian 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 reasonable need 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: _______________________ Relationship to Patient: ____

Signature of Patient or Other Person Authorized to Sign for Patient: ____

Printed Name: ____

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