VI Fire and Emergency Medical Services

INFORMED CONSENT FOR THE RELEASE OF

MEDICAL RECORDS / MEDICAL INFORMATION

1. **Photocopies of the following medical record(s) information contained herein including AID/HIV test results diagnosis, treatment, and related information are released to:**

_____

(Medical Record Information)

Patient's Name: _____ **Date of Birth:** _____

Incident Date: _____ **PRID #:** _____

2. **Medical information to be disclosed and /or photocopies include:**

CAD/Trip No. _____

3. **The above information is released for the following purpose and that purpose only.**

Any use is prohibited without the specific written consent of the patient or an authorized legal representative.

- ☐ **Continuity of Medical Care**
- ☐ **Personal Use**
- ☐ **Attorney Use/Police Investigation**
- ☐ **Financial Resources**
- ☐ **Nursing Home Placement**
- ☐ **Other** _____
- ☐ **Adoption**
- ☐ **Rehabilitation**
- ☐ **Hospital Transfer**
- ☐ **Child / Adult Protective Services**
- ☐ **Certification of Hospitalization**

4. **This verifies I have received the documents requested**

Date: _____ **Time:** _____ **am / pm**

_____ _____

Signature of Parent or Legal Representative **Position/Title**

_____

Witness (Employee Acceptable)

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