



AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

Information requested:

Pre-Hospital Patient Care Report for Run # _____ for service date on ____/____/____

Billing Statement for Run # _____ for service date on ____/____/____

WLAD Patient Signature Form for Run # _____ for service date on ____/____/____

Other (please specify) _____

Release information to: Myself (the patient or representative) to organization/individual below:

Organization Individual Name

Phone Address City State Zip

Purpose of Release: Medical Legal Insurance Personal Other: _____

I hereby authorize **WESTERN LANE FIRE AND EMS AUTHORITY** to use or disclose the protected information from the records of the client listed above. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. **I am aware that this consent is subject to revocation by me at any time unless action has been taken. This consent will expire six (6) months from the date it is signed.**

Signature of Patient or Legal Representative** Date

Printed name of Patient or Legal Representative Relationship or authority to act for patient

**Legal Representative – Document verifying as Legal Rep must be submitted with this request

For Office Use Only: Requested records were; picked up by patient mailed faxed # _____

Date: _____ ID verification: ODL _____ copy attached
 Legal Representative paperwork copy attached

Records copy provided by WLAD Employee Signature: _____