



# 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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