Montgomery County Fire EMS Department
755 Roanoke Street, Suite 2E
Christiansburg, VA 24073
540-394-2120 ext. 54158

Authorization to Release Confidential Health Records

Patient's Name: ______________________________ **Patient's Date of Birth:** _____________

Recipient's Name: ____

Recipient's Address: ____

City: _______________________________ **State:** _______ **Zip Code:** __________

This authorization is applicable to:

- ❑ All healthcare information possessed by MCFEMS
- ❑ Healthcare information related to the following treatment, condition, or date(s):

  ____

- ❑ Other: ____

As the person signing this authorization, I understand that I am giving my permission to Montgomery County FireEMS Department (MCFEMS) for disclosure of confidential health records. I understand that MCFEMS may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to MCFEMS and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that the health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of MCFEMS. I further understand that this authorization will expire thirty (30) days after the date of my signature.

____

Signature

Date: ___________________________

FOR OFFICE USE ONLY

Date Received: _________________________

Received By: __________________________

Date Records Released:

____

Released By: __________________________

Signature: ____________________________

*Forward **immediately** to Deputy Director of EMS*

____

Printed Name

Relationship to Patient (Check One Below)

- ❑ Self
- ❑ Parent/Legal Guardian
- ❑ Other: ____________________

Note: This form MUST be accompanied by a copy of the requestor's photo ID. If the requestor is not the patient, proof of their relationship to the patient must also be attached.