Medical Authorization Release Form

CITY OF HIALEAH FIRE DEPARTMENT

RESCUE DIVISION
83 East 5th Street
Hialeah, FL 33010-4797
Phone: (305) 883-6982 Fax: 305-883-6980

I, _____ hereby authorize the release of all medical information contained
(Name of Patient)

in the Hialeah Fire Department EMS/Rescue Patient Care Record for an incident which occurred on _____/_____/_____
(Date of Incident - m/d/y)

at _____.
(Address of Incident)

I release this information to: _____
(Name of Party Receiving Report -Attorney, Family Member, Friend, etc.)

Address of party receiving the report: _____

Phone of party receiving the report: (_____)_____-_____

_____ Patient's Signature

_____ Patient Name

_____/_____/_____ Patient's DOB

_____ Patient's Address

_____-_____-_____ Patient's SS#

(_____) _____-_____ Patient's Phone

_____ If Minor, Parent or Legal Guardian Signature

_____ Parent or Legal Guardian Printed Name

(_____) _____-_____ Parent or Legal Guardian's Phone

_____ Parent or Legal Guardian's Address

STATE LAW REQUIRES THAT A SUBPOENA OR RELEASE OF MEDICAL INFORMATION FROM THE PARTY BE PRESENTED TO OBTAIN MEDICAL INFORMATION. **WE REQUIRE THAT THE RELEASE BE NOTARIZED.**

Sworn to and subscribed before me this_____ day of_____ 20_____, by

_____, who is personally known or has produced _____ as identification.

My commission expires: _____/_____/_____

_____ Signature Notary Public, State of Florida

_____ Printed Name of Notary Public, State of Florida

The fee for the EMS/Rescue Report is $1.00 per certified page (amount of pages per report will vary). Please call to find out how many pages. Cash, check, and credit cards except AMEX are accepted. Checks payable to HIALEAH FIRE DEPARTMENT.

Total # of pages _____ Amount Due $_____ INCIDENT # _____