Tualatin Valley Fire & Rescue

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This Authorization must be signed by the patient or by a person authorized by law to represent the patient.

Please attach one copy or photo of a legal form of identification for the signer.

Patient Name: _____ Date of Birth: _____

Date(s) and/or Incident Number(s): _____

Purpose of Request: _____

I authorize Tualatin Valley Fire & Rescue to release a copy of my medical record to the individual or entity named below. I specifically authorize the release of information pertaining to drug or alcohol abuse, psychological or psychiatric conditions, and/or communicable disease information, if such information is part of the patient care report. I understand this record may be voluminous and agree to pay all reasonable charges associated with providing this record.

Release To: _____

Street Address: _____

City/State/Zip: _____

Phone or Email: _____

This Authorization may be revoked at any time by submitting a written request to the Tualatin Valley Fire & Rescue Records Department. The only exception is when action has already been taken to release records in accordance with the Authorization. Unless revoked, this consent will expire 180 days from the date of signing.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand Tualatin Valley Fire & Rescue will not condition treatment, payment, enrollment or eligibility on whether I sign this Authorization.

Signature of Patient or Personal Representative: _____

Date: _____

Legal Identification Attached:

☐ Driver's License ☐ Social Security Card ☐ Passport ☐ Medical Power of Attorney ☐ Other