

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. _____
Patient Name: Last, First, Middle Initial _____
Date of Birth

Street Address _____
Date of Incident(s)

City State Zip

2. Records released from: **City of Madison Fire Department**
325 W. Johnson St.
Madison, WI 53703

3. Release records to: _____
Name _____
Street Address _____
City State Zip
Phone: _____

4. Extent of information to be disclosed: Single incident All incidents
Type of information to be disclosed: EMS report(s) Ambulance bill(s)

5. Purpose or need for disclosure. (Check applicable categories):
_____ Payment of insurance claim _____ Legal investigation
_____ Personal _____ Other: _____

6. The health information listed above may be disclosed to persons who are not subject to federal information privacy laws. These persons may further disclose this health information and it may no longer be protected by federal health information privacy laws.

7. This authorization will remain in effect until: (date): _____

8. This authorization is voluntary. We will not condition your treatment on receiving this authorization.

9. This authorization may be revoked at any time, except to the extent action had been taken based on it. To revoke this authorization submit a written request to:

Madison Fire Department, 325 W. Johnson St., Madison, WI 53703

10. _____
Signature of Patient* 11. Date: _____

**If signed by person other than patient, state relationship and authority to do so:*

Relationship: _____
Patient is: Minor Incompetent/Incapacitated Deceased
Legal Authority: Legal Guardian Parent of Minor Spouse of Deceased
 Health Care Agent _____
 Personal Representative of Deceased Other: _____

12. How would you like to receive the report(s)?
 Mail to above address Fax (list #): _____ Call when ready and I will pick up

****Fee: There is a charge of .25 cents per page plus postage, if applicable. A bill will be included with copy of report(s).**