SHORELINE FIRE DEPARTMENT

Authorization for Release of Information

I hereby authorize and request you to release to _____
(name)

the complete medical records, in your possession, concerning the illness and/or treatment of

_____ by your personnel, on _____
(name) (date and time)

at the following location: _____
(physical location)

I understand that by authorizing the release of these records, I am waiving and relinquishing any privilege or right that I may have, to keep said records confidential or to prevent their disclosure. I hereby agree to hold Shoreline Fire Department and all of its officers, employees and agents, harmless from any and all claims that may be made against them, in conjunction with the release of the above-described records, as herein authorized.

I hereby affirm that the above facts and representations are true and correct.

_____ _____
(Patient Signature) (Date)

_____ _____
(Address) (KCEMS Incident Number)

If you are the Court-Appointed Representative, attach a copy of the Power of Attorney and sign below:

_____ _____
(Signature) (Date)