



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION



I hereby request and authorize the Temple Terrace Fire Department to release the records specified below:

- All General Medical Records
- All General Fire Records
- Limited records (specify) _____

Information:

Patient/Business Name _____

Date of Birth _____

Date of Service _____

Incident Location _____

Incident Number _____

For the purpose of:

- Continuing to receive medical care
- Information for the insurance company
- Information for attorney
- Personal use (specify) _____
- Other (specify) _____

These records will be provided at a cost of \$1.00 per page.

Name of person or agency information is being disclosed to _____

Address _____

City _____ State _____ Zip _____ Phone/Fax Number _____

Authorized by:

Date signed _____ Signature of patient or authorized representative* _____

- Authorized representative
- Parent
- Surviving spouse
- Legal guardian
- Administrator/Executor of Estate*
- Other (specify) _____

*If legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization. The parent or authorized representative may revoke this authorization at any time by submitting a written request to the department. This authorization will expire automatically 60 days after the date is signed.

**NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS
PROHIBITION OF REDISCLOSURE**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by state law, with regard to HIV/AIDS records, a specific, written consent is required. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED