



# Shenandoah County

## Department of Fire and Rescue

600 N. Main Street, Suite 109

Woodstock, VA 22664

(540) 459-6774 Phone

(540) 459- 6192 Fax

wbulatko@shenandoahcountyva.us

### AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

(PLEASE PRINT USING A BLUE OR BLACK INK PEN)

#### Section 1. Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Last 4 Digits of Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Incident/Service: \_\_\_\_\_

#### Section 2. Voluntary Authorization to Release Information

I, \_\_\_\_\_, release from liability and voluntarily authorize, Shenandoah County Department of Fire & Rescue, its agents, servants, employees, officials, and attorneys, to release to the person listed in *Section 3* of this form, printed copies of the information specified in *Section 4* of this form, for the above referenced patient for services provided on the above referenced date only.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to above named patient: \_\_\_\_\_

Witnessed by, Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Reason patient did not sign: \_\_\_\_\_

Reason for Release:  Continued Care  Insurance  Legal  Personal Use

#### Section 3. Name and Address of Person or Organization to Receive Protected Health Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Section 4. Description of Information Authorized for Release

Dispatch Report  Patient Care Report  Billing Information

#### Section 5. For SCFR Use Only

Picture Identification confirmed  Id. Type and number if any: \_\_\_\_\_

Date: \_\_\_\_\_ SCFR Staff Member: \_\_\_\_\_