Shenandoah County

Department of Fire and Rescue

600 N. Main Street, Suite 109
Woodstock, VA 22664

(540) 459-6774 voice
(540) 459-6192 fax

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

By signing this form, I,_____, release from liability and voluntarily authorize, Shenandoah
Patient, Parent, Legal Guardian, or Authorized Representative
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:_____ Patient POA?_____

Reason patient did not sign:_____

Witnessed by, Name:_____ Signature:_____

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

Name:_____

Address:_____

_____

_____

Reason for Release: Continued Care Insurance Legal Personal Use

Section 4. Description of Information Authorized for Release

Patient Care Report Billing Information

Section 5. For SCFR Use Only

Picture Identification confirmed | Id. Type and number if any:_____

Copy of POA with request ☐ Incident Number: _____

Date:_____ SCFR Staff Member:_____