



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 authorized, 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: _____ 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: _____