Central Fire District
Central Fire Ambulance Service
697 Annis Highway
PO Box 217, Rigby, ID. 83442
Office: (208)745-6003 Fax: (208)745-6310

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: _____ DOB: _____

Mailing address: _____

City/State/Zip: _____

Phone #: _____ Date of Service: _____

Patient information needed (check box)

- ○ Personal Use ○ Social Security/Disability ○ Insurance ○ Legal Purposes
- ○ Other: _____
- ☐ Records to be faxed ☐ Emailed to: _____
  Email Address

I, _____authorize the release of medical records to myself or to the above Person/Facility to obtain my medical record. I understand my records are confidential and cannot be disclosed without my written authorization, except written by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected.

The authorization will expire in six (6) months from the date of my signature, unless I revoke with written consent prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Signature

_____
Address, City. State/Zip and Phone # of Legally Authorized

_____
Relationship to Patient