

## MEDICAL INFORMATION RELEASE AUTHORIZATION

Print name of patient:	_____
Date of incident:	_____
Incident location:	_____

**The Columbus Division of Fire is in compliance with the Health Insurance Portability and Accountability Act (HIPAA).**

I, the undersigned, hereby request all information regarding my treatment to be released to: *(print)* \_\_\_\_\_.  
*(person obtaining report)*

Relationship to patient: \_\_\_\_\_

Patient's Name: *(print)* \_\_\_\_\_

### **Verification of identification on both parties should be established**

Signature of patient \_\_\_\_\_

Signature of person obtaining report \_\_\_\_\_

**STATE OF OHIO  
COUNTY OF FRANKLIN, SS:**

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, appeared before me and swore that the foregoing is true to the best of his knowledge and belief.

\_\_\_\_\_  
Notary Public