AUTHORIZATION FOR RELEASE OF STEESE AREA VOLUNTEER FIRE DEPARTMENT EMERGENCY MEDICAL SERVICES REPORT

The Steese Area Volunteer Fire Department Emergency Medical Services Report contains confidential information including medical histories, reports of actions and findings, summaries, diagnoses, records of treatment, medications ordered and administered, notes, entries and other written or graphical material maintained by the Steese Area Volunteer Fire Department pertaining to the individual receiving emergency medical care. By my Signature below, I authorize the Steese Area Volunteer Fire Department to release my Emergency Medical Services Report(s) as follows:

INFORMATION RELEASED TO:

ADDRESS:

PATIENT'S NAME:	**AGE**	**DATE OF BIRTH**

ADDRESS:

REASON FOR RELEASE & DISCLOSURE:

☐ At request of Patient [No description required]
☐ Other: Describe purpose_____

INFORMATION TO BE RELEASED:

☐ The entire Steese Area Volunteer Fire Department Report for the Incident described below.

☐ Other (be specific): _____

HIV-RELATED INFORMATION AND/OR RECORDS WILL NOT BE INCLUDED UNLESS THE PATIENT SPECIFICALLY REQUESTS IT TO BE. THE LINE BELOW MUST BE INITIALED BY THE PATIENT FOR THAT TYPE OF INFORMATION TO BE RELEASED:

I authorize the release of HIV/AIDS related health information and/or records. _____ (Patient's Initials)

DATE OF SERVICE:	**TIME** ☐ AM ☐ PM

LOCATION OF INCIDENT (STREET LOCATION WHERE INCIDENT OCCURRED):

EXPIRATION:
Unless otherwise revoked, this authorization expires _____ (insert date or event).
If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

NOTICE:

1. You may revoke this authorization at any time except to the extent Steese Area Volunteer Fire Department has taken action in reliance upon this authorization. To revoke this authorization, you must do so in writing and submit it to Steese Area Volunteer Fire Department, 800 William C Leary Lane, Fairbanks, AK 99712.
2. You may refuse to sign this authorization. You do not need to sign this authorization to receive services from this Department. If you refuse to sign this authorization, you will not be denied any treatment or benefits to which you were otherwise entitled.
3. Once your information is disclosed pursuant to this authorization, it may no longer be protected by Alaska or Federal privacy law, and the person or organization that receives your information may have the legal right to disclose the information to other people or organizations without your knowledge or consent.

PATIENT'S SIGNATURE OR REASON IF THE PATIENT IS UNABLE TO SIGN:	**DATE**:

RECORDS MAY NOT BE RELEASED WITHOUT SIGNATURE OF PATIENT. If a patient is unable to sign (e.g., minor, deceased, physically or mentally incapacitated), a **legally qualified** representative (parent, next of kin, legal guardian, spouse administration, executor of estate) may sign in lieu of patient. If this authorization is signed by someone who is not the patient listed at the top of this form, provide proof and a description of the signer's legal authority to act for the patient.

For minor child releases ONLY: If patient is a minor child (under age 18), the undersigned states that he/she (Requestor) is either the legally appointed guardian, or is the child's parent, and Requestor has not been denied access to the minor's records in any court proceeding and, to the Requestor's knowledge, is not currently under investigation by any child welfare or law enforcement agency.

SIGNATURE OF LEGALLY QUALIFIED REPRESENTATIVE (READ STATEMENT ABOVE)	**DATE:**
REPRESENTATIVE'S NAME (PRINT):	**RELATIONSHIP TO PATIENT**:

IF THE INDIVIDUAL SIGNING THIS FORM IS NOT PRESENT, THE SIGNATURE MUST BE NOTARIZED.

NOTARY:

FOR OFFICE - WHEN PRESENTED IN PERSON PROOF OF IDENTITY AND LEGAL AUTHORITY IS REQUIRED. TYPE: Approved by:	***IS PROOF OF LEGAL AUTHORITY ATTACHED?*** ☐ YES ☐ NO – reason _____