MEDICAL INFORMATION RELEASE AUTHORIZATION

Print Name of Patient: _____

Date of Incident: _____

Incident Location: _____

I, _____ hereby request my EMS Report from the
(Please Print Patient's Name)
Columbus Division of Fire regarding my treatment on _____ be released to:
(date(s) of incident)

_____
(Please print name of designated representative receiving report)

Relationship to patient: _____

Signature of designated representative obtaining report:

_____

Signature of Patient:

_____

STATE OF OHIO
COUNTY OF FRANKLIN, SS:

On this _____ day of _____, 20____,

both of the above named individuals appeared before me and swore that the foregoing is true to the best of his/her knowledge and belief.

(seal)

_____
(Notary Signature)

_____
(Commission Expiration)

Administration Bureau | 3675 Parsons Avenue | Columbus OH 43207 | **T** (614) 645.6017 | **F** (614) 645.3040
Emergency Services Bureau | 3639 Parsons Avenue | Columbus OH 43207 | **T** (614) 645.4128 | **F** (614) 645.4204
Fire Prevention Bureau | 3639 Parsons Avenue | Columbus OH 43207 | **T** (614) 645.7641 | **F** (614) 645.4245
Support Services Bureau | 3639 Parsons Avenue | Columbus OH 43207 | **T** (614) 645.6385 | **F** (614) 645.0110
Training Bureau | 3639 Parsons Avenue | Columbus OH 43207 | **T** (614) 645.6360 | **F** (614) 645.3214
fire.columbus.gov