

## 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)

