TOWN OF

MANCHESTER FIRE-RESCUE-EMS DEPARTMENT

DEPARTMENT

Authorization to Release Medical Information

I hereby authorize the Manchester Fire-Rescue-EMS Department to release my *Patient Care Report* pertaining to the following incident:

Date:_____ Location:_____ Time:_____

Type of Incident:_____

Name of Patient:_____

Address of Patient:_____

City:_____ State:_____ Zip Code:_____

Date of Birth of Patient:_____

This authorization shall become effective immediately and shall remain in effect for ninety (90) days from date signed. This authorization is subject to revocation at any time.

I understand that information used or disclosed based on this authorization may not be protected from further disclosure by the recipient of the information.

This form shall be notarized or signed by a Commissioner of the Superior Court unless presented, in person, by the subject of the *Patient Care Report* who shall provide indisputable personal identification.

_____ _____

Signature of Patient Date

Sworn to before me this _____ day of _____, 20_____

_____

Notary Public

RELEASE PCR TO:_____

_____

_____