AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: **Incident No. (If known):**

Date of Birth: **Driver's License:**

I authorize Bellevue Fire Dept to release the information as stated below:

INFORMATION TO BE RELEASED TO:	
☐ **Myself**	
☐ **Other Name (Organization/Person):**	
Street Address:	
City, State, Zip:	
Phone:	**Fax:**
RECORD SEARCH INFORMATION:	
Location where service was provided (address or cross-street):	
Date of Service:	
AUTHORIZATION FOR RELEASE OF INFORMATION:	
I UNDERSTAND that by authorizing the release of these records, I am waiving and relinquishing any privilege or right which I may have to keep said records confidential or to prevent their disclosure; and I hereby agree to hold the city of Bellevue and all of its officers, employees and agents harmless from any and all claims that may be made against them on account of the release of the above-described records as herein authorized.	
SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE:	
Signature of Patient or Legal Representative	**Date (month/day/year)**
Relationship to patient, if not signed by patient, and description of Authority	
Requesting Medical Records on Behalf of Another Person: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc.	

Send completed form and any attachments by fax to (425) 452-5287, or mail to the address below.

Medical Records
Bellevue Fire Dept
450 110th Ave Ave NE
Bellevue, WA 98004