AUTHORIZATION TO RELEASE INDIVIDUAL MEDICAL RECORDS

Name Of Patient: _____ ("Patient")

Patient's Address: _____
Street Address City

Requested By: _____("Requestor")

Relationship Between Requestor and Patient: _____

I, _____ hereby authorize the release of the following medical
(patient)
information to DU-COMM and its member public safety agencies that it serves. Medical Information:

_____

_____

_____

_____

_____

_____

_____

_____

I understand that my medical information is confidential and protected by physician-patient privilege. I waive the physician-patient privilege relating to the authorization for release of my confidential medical information. I understand that I may revoke this authorization any time after written notice to DU-COMM except to the extent that prior action has been taken on the basis of this authorization. I further understand that this information may be disseminated over the police and/or fire radio system and that the general public utilizing the proper radio receiving equipment can hear these radio transmissions.

Date: _____

Patient Signature: _____
(Note: Requestor may sign for patient if patient is a minor child and requestor has legal custody; or if requestor has medical power of attorney for patient)

Type/Print Patient Name: _____

Witness Signature: _____

Type/Print Witness Name: _____

FOR DU-COMM USE ONLY

Entered By: _____ Date: _____

Time Entered: _____