Valley Regional Fire Authority
1101 D Street NE
Auburn, WA 98002
Office: (253) 288-5800
Fax: (253) 288-5970

Authorization for the Release of Medical Records of an Adult Patient

REQUIRED: **Please attach a copy of the government-issued photo ID** of the person whose signature appears on this document for the release of records

I, _____

The undersigned, does hereby certify as follows:

I received emergency medical treatment from VALLEY REGIONAL FIRE AUTHORITY EMS personnel. I hereby request and provide permission to the VALLEY REGIONAL FIRE AUTHORITY PUBLIC RECORDS OFFICER to release, to myself or legal representative, a complete copy of all records, including reports, notes, comments, and professional opinions developed in the course of treating me for my injuries and/or illness suffered on or about _____ [date] and treated on or about _____[date] at the location of _____ [address or location].

With this authorization, I release the VALLEY REGIONAL FIRE AUTHORITY as the medical records provider from all legal responsibility or liability that may arise from the release of this information to myself or legal representative. This Authorization is subject to my written revocation at any time, except to the extent action has been taken in reliance thereon.

I understand that this Authorization shall expire NINETY (90) days after the date of signing this Authorization. A reproduction of this form shall be, for all intents and purposes, considered as valid as the original of this Authorization. This Authorization to release medical records is made in compliance with RCW 70.02.030 and RCW 71.05.

I understand that once the VALLEY REGIONAL FIRE AUTHORITY discloses my health information, the person(s) or organization that receives the released health information may redisclose it, at which time it may no longer be protected under privacy laws.

DATED this _____ day of _____, 20____.

_____	_____	_____
Signature of Patient	Printed Name	Driver's License or WA State ID No.

WITNESS SIGNATURE BOX (if applicable)*

DATED this _____ day of _____, 20____.

_____	_____	_____
Signature of Witness *	Printed Name	Driver's License or WA State ID No.

*Applicable if requestor is *not* the patient and has *power of attorney,* or is legally authorized to receive medical records on behalf of the patient

PLEASE FORWARD COPIES TO: _____

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