Loudoun County
Fire, Rescue and Emergency Management
Medical Release Form

Authorization to Release Medical Information

Patient's Name: ______________________________ Patient's Date of Birth: __________________________

I request and authorize the Loudoun County Department of Fire, Rescue and Emergency Management to provide healthcare information in its possession that pertains to the patient named above and release that information to:

Name: ____

Address: ____

City: ____________________ State: ________________________ Zip Code: ____________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

____

☐All healthcare information

☐Other: ____

Signature: ____ Date Signed: ____

Relationship to patient: ☐Self ☐Parent of Minor Child ☐Guardian ☐Legally Authorized Representative

Documentation to establish identity (e.g. copy of a Driver's License) or relationship/legal authorization must be provided with this request.

THIS AUTHORIZATION EXPIRES NINTY DAYS AFTER IT IS SIGNED.