



CLAY FIRE

18355 Auten Road • South Bend, IN 46637 Telephone: (574) 272-2144
Fax: (574) 272-4043
Internet: www.clayfd.com

REQUEST FOR RELEASE

Patient Name: _____ Date Of Birth: _____

Patient Address: _____

Phone: _____ Email: _____

I hereby authorize the: Clay Fire Territory
18355 Auten Road
South Bend, IN 46530

To release (type of record): _____

For the purpose of: _____

Date of Service: _____

Address of Service: _____

I understand that the information in my health record may include information relating to my mental health, drug, alcohol and/or HIV, AIDS or communicable disease.

It is understood that this authorization is subject to written revocation by me at any time except for information that has already been released in response to this authorization. This authorization shall remain valid until revoked and will expire in 60 days or upon the following conditions:

_____.

Signature of Patient Date Signed

Signature of Other Authorized Person** Date Signed

Relationship of Other Authorized Person _____

**The signature of a parent (including a non-custodial parent provided that there are no court-ordered restriction) or legal guardian is required for any unemancipated patient under the age of 18. A parent, guardian or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative is available, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for the deceased patient.