PATIENT MEDICAL RELEASE AUTHORIZATION

ATTENTION: Rutherford First Aid Ambulance Corps Squad Captain:

I am requesting a copy of the ambulance call sheet for the call and patient noted below.

NAME OF PATIENT: _____

ADDRESS OF PATIENT: _____

_____

DATE OF BIRTH OF PATIENT: _____

DATE OF AMBULANCE CALL: _____

LOCATION OF AMBULANCE CALL: _____

YOUR RELATIONSHIP TO PATIENT ON MEDICAL REPORT REQUESTED:
(Patient, Parent, Legal Guardian) _____

YOUR PHONE NUMBER: _____

YOUR ADDRESS: _____

_____

I hereby certify that the above answers and information are true. I further attest to the fact that I am the patient listed on the ambulance call report requested, and/or the parent or guardian of such patient.

Print Your Name: _____

Your Signature: _____

Dated: _____

NOTE: Return this signed completed "Patient Medical Release Authorization" Form to the Rutherford First Aid Ambulance Corps, P.O. Box 217, Rutherford, New Jersey 07070, Attention: Squad Captain. Enclose a self addressed stamped envelope to facilitate return of the Ambulance Medical Report. ALSO, provide a copy of your Photo Driver's License OR two other forms of identification noting your Name and Address, i.e. Tax Bill, Utility Bill, Insurance Bill, Bank Statement, Vehicle Registration, Non-Photo Driver's License, County ID, School ID, Voter Registration. NO REQUESTS WILL BE HONORED WITHOUT THE PROPER IDENTIFICATION. We can only mail a copy of the report to the address indicated on your forms of identification. If any of the information indicated above does not correlate to the information on the ambulance call sheet, the request will be denied.