

**WEST THURSTON REGIONAL
FIRE AUTHORITY
10828 Littlerock Rd SW
Olympia, WA 98512
360-352-1614**



AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize and request West Thurston Regional Fire Authority (WTRFA) to release to:

Name _____

Address _____

the complete medical records in your possession concerning the illness and/or treatment of (patient's name):

by your personnel on:

Date _____ **Incident # (s)** _____

Incident Address _____

I understand that by authorizing the release of these records, I am waiving and relinquishing any privilege or right which I may have to keep said records confidential or to prevent their disclosure. I hereby agree to hold WTRFA and all of its officers, employees and agents harmless from any and all claims that may be made against them on account of the release of the above-described records as herein authorized.

PATIENT OR NEXT OF KIN

RECORDS RECIPIENT

(if other than patient or next of kin)

I hereby affirm that the above facts and representations are true and correct:

Signature (Patient or Next of Kin)

Signature of Records Recipient

Relationship to Patient

Affiliation or Relationship to Patient

Street or Mailing Address

Street or Mailing Address

City State Zip

City State Zip

Date

Date

Signed and sworn before me on this _____ day of _____

Signature of Notary Public _____

Printed Name of Notary Public _____

Residing At _____

Expiration of Notary Appointment _____

Notary Seal

WTRFA Only

Type of ID _____

Copy of ID Attached

Name on ID _____

Staff Witness / Date _____

NOTICE of Information Practices

MEDICAL RECORDS

We keep a **record of health care services** we provide to you. You may ask us to see and copy that record(s). You may also ask us to correct that record. We will not disclose your records to others unless you direct us to do so or **UNLESS** the law authorizes us to do so. You may see your record or get more information about it at:

***West Thurston Regional Fire Authority
10828 Littlerock Rd SW
Olympia, WA 98512***

I acknowledge that I have received a copy of this Privacy Practice Notice.

Signature: _____

Print Name: _____

07/30/2014 Notice of Information Practices
RCW 70.02.120