Carlsbad Fire Department

Request for Release of Patient Medical Records

(PLEASE PRINT)

Today's Date: _____

Requestor's Name: _____

Mailing Address: _____

City, State, ZIP: _____

Phone #: _____

RE: Release of medical records for_____ DOB:_____

Please release the medical records for the above named patient related to the incident that occurred as follows:

Incident Date(s): _____

Approximate Time(s): _____

Incident Location(s): _____

Please find my records fee of $15.00 ☐ **check** OR ☐ **cash** enclosed.
MAIL THIS FORM ALONG WITH YOUR PAYMENT TO: our address below

IMPORTANT: **If you are requesting records for someone else,** you will also need to provide one of the following (upon request by CFD staff):

1.) copy of *Power of Attorney* or signed release from the patient
2.) For a minor patient - proof of parenthood (i.e. birth certificate)
3.) For a deceased patient – copy of *Durable Power of Attorney* OR *Power of Attorney Medical*.

Please note: Allow10-14 days for processing. We will call you when reports are ready for pick-up. It is our policy not to email, fax or mail medical records.

FOR PICK-UP: Photo ID required Signature: _____