



**CITY OF HIALEAH FIRE DEPARTMENT**

**RESCUE DIVISION**  
83 EAST 5<sup>TH</sup> STREET  
HIALEAH, FLORIDA 33010-4797  
PHONE: (305) 883-6982 FAX: 305-883-6980

**BILLING DEPARTMENT**  
83 EAST 5<sup>TH</sup> STREET  
HIALEAH, FLORIDA 33010-4797  
PHONE: (305)883-5919 FAX: 305-863-2845

I, \_\_\_\_\_ hereby authorize the release of all medical information contained on the Rescue Patient Record for the incident which occurred on: \_\_\_\_\_

The address of the incident was: \_\_\_\_\_

I release this information to: \_\_\_\_\_  
(Attorney, Friend, Family Member etc.)

Address of party receiving the report: \_\_\_\_\_

Phone number of party receiving the report: \_\_\_\_\_

Print name of party receiving the report. \_\_\_\_\_

If Minor Print Parent or Legal Guardian Name: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
If Minor, Parent or Legal Guardian Signature

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS # \_\_\_\_\_  
Client / Patient's Name

Phone: \_\_\_\_\_ Address \_\_\_\_\_

**STATE LAW REQUIRES THAT A SUBPOENA OR RELEASE OF MEDICAL INFORMATION FROM THE PARTY BE PRESENTED TO OBTAIN MEDICAL INFORMATION. **WE REQUIRE THAT THE RELEASE BE NOTARIZED.****

**The charge for report is \$4.50 Standard Report (1 to 4 pages). Additional pages @ \$1.00 per certified page. Make all checks payable to HIALEAH FIRE DEPARTMENT.**

**Total of pages** \_\_\_\_\_

**Amount Due \$** \_\_\_\_\_

\_\_\_\_\_  
NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT AND/OR LEGAL GUARDIAN

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 2013.

BY \_\_\_\_\_ who is personally known or has produced \_\_\_\_\_ as identification.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public, State of Florida

**INCIDENT #** \_\_\_\_\_