StoweEMS
P.O. Box 291 Stowe, VT 05672

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby grant my permission for Stowe EMS (Town of Stowe, Vermont, Department of Emergency Medical Services) to release any/all Protected Health Information relative to care provided to me. I am asking for any records pertaining to care provided during the following time period or on the date specified hereafter:
I ask for this information to be released to the following person(s):

Name

Address:

Address:

City State Zip

Phone: Fax:

Email:

I request the information released to be: ☐ mailed ☐ faxed ☐ emailed.
This authorization will expire one year from the date it has been requested unless I indicate an earlier date or event here:

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature Date Signed

Printed Name of Person Signing
Relationship to Patient
Mailing Address

Department of Emergency Medical Services
P.O. Box 730 350 South Main Street Stowe, Vermont 05672
Phone 802.253.9060 FAX 802.253.2927