StoweEMS

P.O. Box 291 Stowe, VT 05672

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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.

- **Kh'vj g'r cvkgpv'ku'3: '{ gct u'qh'ci g'qt 'qnf gt**, the patient must sign and date the form.
- **Kh'vj g'r cvkgpv'ku'3: '{ gct u'qh'ci g'qt 'qnf gt 'cpf 'ku'kpecr cdng'qh'uki pkpi**, 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)
- **Kh'vj g'r cvkgpv'ku'39'{ gct u'qh'ci g'qt '{ qwpi gt**, 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

D e p a r t m e n t o f E m e r g e n c y M e d i c a l S e r v i c e s

P.O. Box 730 350 South Main Street Stowe, Vermont 05672

Phone 802.253.9060 FAX 802.253.2927