



## Authorization To Release Healthcare Information

Patient Name \_\_\_\_\_

Patient Social Security Number \_\_\_\_\_

Patient Date Of Birth \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release

healthcare information of the patient named above to:

Care First EMS  
1451 Empire Central  
Dallas, TX 75247

This request and authorization applies to:

History, medical and physical information

Other (please describe): \_\_\_\_\_

\_\_\_\_\_

X \_\_\_\_\_

**Patient or Responsible Party Signature**

\_\_\_\_\_ **Date**