SPRING GROVE FIRE PROTECTION DISTRICT

8214 Richardson Rd. Spring Grove, IL 60081
Phone: 815-675-2450 | Fax: 815-675-6284 | springgrovefire.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patients Name: _____ Date of Birth: _____

I, _____, authorize the Spring Grove Fire Protection District to release a
(NAME OF PATIENT or, PARENT/GUARDIAN IF PATIENT IS A MINOR)

copy of my treatment/transport records and any billing records, or those of

_____, for the date(s): _____
(NAME OF PATIENT IF A MINOR)

Records should be sent to:

(NAME/INSURANE AGENCY) _____

(ATTENTION TO) _____

(ADDRESS, CITY, STATE, ZIP) _____

(EMAIL) _____

(FAX) _____

Please indicate how you would like to receive these records:

☐ Mail ☐ Email ☐ Fax

Please provide your insurance information as it speeds up the insurance companies' ability to process the claim.

_____
(PRIMARY INSURED)

_____
(INSURANCE POLICY TYPE) **(POLICY #)**

_____
(CLAIM #)

Signature of patient or guardian: _____ Date signed: _____

Printed name of patient or guardian: _____ Date signed: _____