CITY of WEST ALLIS
FIRE DEPARTMENT

WEST ALLIS FIRE DEPARTMENT
INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION
CHAPTER 145, WISCONSIN STATUTES

I, ______________________________ born on __________________________________
(Name of Patient) (Date of Birth)

authorize the City of West Allis Fire Department, through its officials and employees, to disclose to
____.
(Specify Individual, Agency, Organization, etc.)

information from my health care records, maintained by the Department, and to provide copies of same. I understand that the specific type of information to be disclosed includes:
____
____
____
and that this disclosure is being made for the following purpose(s): ___________________________
____

A photocopy of this Informed Consent for Disclosure document may be accepted in lieu of an original.

I release the City of West Allis Fire Department, its officials and employees, from all legal responsibility or liability in connection with the disclosure of the health care information which I have requested.

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it. Unless revoked, this consent will remain in force until:
____

_______________________ _________________________________
(Date of Signature) (Signature of Patient)

______________________ _________________________________
(Date of Signature) (Person Authorized by the Patient)

____
(Relationship to Patient)

Note: Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, an adult member of the deceased patient's immediate family may qualify. A court appointed temporary guardian to consent to the release of records my also qualify.