

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

To Whom It May Concern:

I \_\_\_\_\_ authorize and direct  
Bangs Ambulance, Inc. to furnish to \_\_\_\_\_

\_\_\_\_\_

all information and records, or copies of records, relative to treatment and  
transport rendered to me, on the following date(s):

From \_\_\_\_\_ to \_\_\_\_\_

Dated \_\_\_\_\_

\_\_\_\_\_  
Patient – Print Name

\_\_\_\_\_  
Patient – Sign Name