

Please complete this form and provide a copy of your valid picture identification to
Schertz EMS Department 1400 Schertz Parkway Building 9, Schertz, TX 78154



Schertz EMS Department

Disclosure of Protected Health Information Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Last Date of Service: _____

I, _____, hereby authorize the Schertz EMS Department to
release the following protected health information,

Schertz Emergency Medical Services Patient Care Report

Schertz EMS Academy Class Record

Schertz EMS Shot Record

The purpose for the use and/or disclosure of this protected health information is:

Authorization disclosure termination date: _____

I acknowledge that I have signed a consent form of the Schertz EMS Department. I
understand that I have the right to view or copy my protected health information to be used
and/or disclosed as permitted under federal and/or state law.

Signature _____ Request Date: _____