PROWERS COUNTY SHERIFF'S OFFICE
103 E. OAK ST, LAMAR, COLORADO 81052-0391
719-336-8050 719-336-7900 fax

PATIENT'S AUTHORIZATION FORM

Requesting Deputy: _____ Date: _____

Case Report #: _____ Location: _____

I, _____, DOB/_____,

hereby give my full and voluntary consent and permission to any hospital, medical clinic, any doctor, any nurse, or ambulance personnel, any psychologist or mental health clinician, medical/mental/records/bookkeeping personnel to give the above list law enforcement agency and any of their authorized representatives, any and all information, complete copies of my medical records or files, copies of doctor's reports, hospital logs, operating room logs, any notes, any documentation, and any other related data concerning information desired in connection with the mental and/or physical condition of myself in reference to this investigation.

Alcohol / Drugs / Psychiatric / Infectious Disease records are protected by Federal Regulation 42 CFR, part 2. Release of such requires specific consent. I hereby grant such specific consent of those records.

_____ _____
Signature of Person/Patient authorizing release Date

_____ _____
Signature of Parent or Guardian (if applicable) Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Requesting Deputy Date