DAKOTA 911
POLICE • FIRE • EMS

MEDICAL RELEASE

I authorize release of any medical information necessary to determine whether I/my family member qualifies for Family Medical Leave (FMLA). I understand that my records are protected under state and/or federal privacy laws and cannot be disclosed without my written consent unless otherwise provided for by state or federal law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In any event, this consent expires automatically one year following date of signature without any express revocation.

PATIENT NAME: _____

Signature: _____ Date: _____