



**DEPARTMENT OF PUBLIC SAFETY**  
**EMERGENCY MEDICAL SERVICES DIVISION**  
**3601 NORTH DUPONT HIGHWAY**  
**NEW CASTLE, DELAWARE 19720-6315**  
**Phone (302) 395-8184**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_, as the patient, date of birth of \_\_\_\_\_ and Social Security Number of \_\_\_\_\_ hereby request the release of a copy of the *New Castle County Paramedic Report* dated \_\_\_\_\_, resulting from a response by paramedics from the New Castle County Emergency Medical Services Section. The patient care report may be released to \_\_\_\_\_.

Incident Location: \_\_\_\_\_

Date of Response: \_\_\_\_\_ Approximate Time of Response: \_\_\_\_\_

**My signature verifies that I have legal authority to obtain the aforementioned patient's confidential medical records. Additionally, a copy of this authorization shall be considered as true and valid as the original.**

\_\_\_\_\_  
Requestor's Signature

\_\_\_\_\_  
Relation to Patient / Requestor Date of Birth

\_\_\_\_\_  
Notary Public

Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Date