CENTRAL FLORIDA TOURISM OVERSIGHT DISTRICT

P.O. Box 690519
Orlando, FL 32869-0519
(407) 828-2241

Information Services

REQUEST FOR EMERGENCY MEDICAL SERVICES REPORT

I, _____, hereby request a copy of the emergency medical services report generated on the date of incident indicated below **for services rendered to me** by District Fire Department personnel. I consent that I have not falsified any information on this form in order to obtain a copy of confidential medical information that does not belong to me.

Name of Requestor/Patient:_____

Name of Parent(s) / Legal Guardian if a Minor:_____

Patient Date of Birth (MM/DD/YYYY):_____

Location of Incident:_____

Date & Time of Incident:_____

Email or Mailing Address to Send Records:_____

_____

Contact Information (Phone #/Email):_____

Requestor Signature:_____ **Date:**_____/_____/_____

NOTARY

The intent of this notarization is to confirm the identity of the person requesting confidential medical records. If records being requested are that of a minor, then this serves as proof of parental custody or legal guardianship of the minor.

_____ _____/_____/_____

Notary Signature *Date*

NOTARY STAMP

Upon completion, please upload as an attachment to your request using our JustFOIA online request portal (https://oversightdistrict.justfoia.com/publicportal/home/newrequest) or via mail to the Central Florida Tourism Oversight District, P.O. Box 690519, Orlando, FL 32869; Attn: Public Records Office