

*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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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**NOTARY**

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

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

The foregoing Request was sworn to (or affirmed) and subscribed before me by means of  physical presence or  online notarization, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_, (Name of Requestor) as the \_\_\_\_\_ (Type of Authority: Patient or Legal Guardian of Patient) who is:

personally known to me OR

produced the following identification: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public - State of Florida

(Notary Seal)

\_\_\_\_\_  
Print, Type, or Stamp Commissioned Name or Notary Public

**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**