DEPARTMENT OF FIRE, RESCUE AND
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OPERATIONS DIVISION
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Request for Information

SECTION 1 (Must be completed for all requests)

Name: _____ Today's Date: _____
Address:_____
Phone Number: _____ E-Mail Address: _____

Information requested: ☑ Fire Report ☐ Medical Report ☐ Other

Location of incident: _____
Nature of incident: _____ Date of incident (MM/DD/YY): _____

Reason for request: _____
_____
_____
_____

SECTION 2 (Must be completed for medical report requests)

Relationship to Patient: _____
Name of Patient: _____ Date of Birth: _____
Is Patient Deceased: Yes No ☒ Unknown Date of Death: _____

Do you have one or more of the following medical release authorizations?
__Power of Attorney; __Living Will; __Release from person when living;
__Certification by Circuit Court as sole heir/executor

If not related to the patient, indicate agency or organization affiliation giving you authority or cause to obtain records: _____

Signature*: _____ Time submitted: _____

*All medical documentation must be picked up in person by the requesting individual, and picture identification must be presented at that time unless other previously approved arrangements have been made.