Aptos/La Selva Fire Protection District
Attn: Custodian of Records Office
6934 Soquel Drive, Aptos, CA 95003 (831) 685-6690

REQUEST FOR EMERGENCY RESPONSE RECORDS WITH MEDICAL INFORMATION

The Aptos La Selva Fire Protection District (ALSFD) makes every effort to comply with requests for public records under the California Public Records Act while ensuring compliance to Federal (HIPAA) and State (CMIA) Laws for Protected Health Information (PHI). There may be a fee required.

The attached 'Authorization for Use & Disclosure of Protected Health Information and Records' form must be fully executed and provided along with this request by either US MAIL or in person before records are searched for and provided.

Please search and if available provide the Fire District record types highlighted below:

- ❐ INCIDENT REPORT. Report created by the Incident Commander that complies with the rules of the National Fire Incident Reporting System (NFIRS).
- ❐ FIRE INVESTIGATION REPORT. Not all fires will have a Fire Investigation Report. Depending on the incident complexity and other factors a report may not be completed for weeks or months.
- ❐ MEDICAL REPORT. Not all responses will have a medical report created by a Fire Responder.
  - ❐ Please search for the following:____

____

INCIDENT INFORMATION

Incident Number (if known, assigned by ALSFD, not by law enforcement): ______________________

Date (required): __________Time (estimate): _________Incident Type (fire, accident, etc): ______________

Address/Location (required): ____

Cross Street (if known): ____________________ City/Community (required): ________________

REQUESTOR INFORMATION

Requestor:______________________ Phone:______________ FAX:________________

Email:____________________ Mailing Address:______________________________

SUBMISSION IS ONLY BY US MAIL OR IN PERSON AT ADMINISTRATION OFFICES

ADMIN USE ONLY:

Date Request Submitted:________________ Initials:____________

Date Records Provided:________________ Initials:____________

Number of Pages:________ Fee:__________ Paid:______________

Service Fee: $5 for 1st Page, $2 for each additional page.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

Aptos La/Selva Fire Protection District (ALSFD) Medical Release

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et* seq. (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 *et* seq.].

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

If you have any questions about this authorization, please contact the Custodian of Records, Aptos/La Selva Fire Protection District, 6934 Soquel Drive, Aptos, California, 95003, (831) 685-6690.

PLEASE PRINT LEGIBLY

I, ____hereby authorize Aptos La Selva Fire Protection District (ALSFD) to disclose the protected health information and records of:

Patients Name:___________________________________ Patients Date of Birth:_________________________________

To be released to (select one): ❒ myself ❒ my personal representative

For the purpose of: ____

Incident Date:____________________________________ Incident Time: ______________________________

Incident No. (assigned by ALSFD, Not by the CHP/Police):____

Address/Location, with nearest cross street (if known): ____

____

____

This authorization is limited to the following information relating to my past, present, or future physical or mental health or condition:

☐ **Complete health record(s) and other records** for the following dale of service, which may contain all of the documents listed below, as well as other notes/documents relating to my treatment:

____

____

☐ **Complete health record(s) and other records** for the following date of service, excluding the following records:

____

☐ **The following health records or other records**:____

____

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

Aptos La/Selva Fire Protection District (ALSFD) Medical Release (Continued)

EXPIRATION

This authorization shall be in force and effect until _______________________, at which time this authorization to disclose this protected health information and records expires.

PATIENT'S RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Records Department at Aptos La/Selva Fire Protection District, 6934 Soquel Drive, Aptos, California 95003. I understand that a revocation is not effective to the extent that ALSFD has relied on the use or disclosure of the protected health information.

ALSFD will not condition my treatment on whether I provide authorization for the requested use or disclosure, unless as otherwise specifically allowed by law.

I understand that California law prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law. However, if the recipient of my health information is not located in California, I understand that the information used or disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal law or by the law of the state in which the recipient is located.

I understand that I have a right to receive a copy of this authorization upon my request. In addition, if ALSFD has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

___________________ Initials of Custodian of Records that a copy of the release was provided.
SIGNATURE

____ ______________________________
Signature of Patient or Personal Representative Date (month/date/year)

____
Print Name of Patient or Personal Representative

<u>NOTE:</u> If signed by a Personal Representative of the Patient, please complete the *Affidavit In Support of Request for ALSFD Medical Records* on page 3.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

AFFIDAVIT IN SUPPORT OF REQUEST FOR ALSFD MEDICAL RECORDS

I, ____ DECLARE AS FOLLOWS:

1. I am the personal representative or beneficiary of__________________________________.
   (name of person whose records you are seeking)

2. The authority for me to act in that capacity is as follows [**please provide a copy of any document(s) that you have which grant you authority to request the subject records**]:

   - ☐ I am the legal guardian.
   - ☐ I am acting pursuant to a durable power of attorney.
   - ☐ I am the conservator of the person.
   - ☐ I am the executor of the estate of the person whose records are sought.
   - ☐ Other (please describe):____
     ____
   - ☐ If the records are of a decedent, at least 40 days have elapsed since the death of the decedent, and no proceeding is now being or has been conducted for administration of the decedent's estate.

3. If the records are of a decedent, at least 40 days have elapsed since the death of the decedent, and no proceeding is now being or has been conducted for administration of the decedent's estate.

4. On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS.

5. The foregoing is true and correct of my own personal knowledge.

I declare under penalty of perjury that the foregoing is true and correct. Executed at:

____ Date: ________________________________
(city, state) (month/day/year)

____
Print Name and Affix Signature