FAIRBANKS FIRE DEPARTMENT

1101 Cushman Street, Fairbanks, AK 99701
(907)450-6600 Fax (907)450-6666
TTY/TTD (800)770-8973 RELAY Alaska
fire@ci.fairbanks.ak.us

MEDICAL RECORDS RELEASE

Patient Name:_____
Patient DOB:_____
Date(s) of Service:_____

This document authorizes and instructs the Fairbanks Fire Department to furnish to:

_____
(Insert the name of the person or entity authorized to receive the protected health information)

The following specific medical record(s) constituting protected health information "PHI" as that term is defined by the Health Insurance Portability and Accountability Act of 1996 (HIPPA-P.L. 104-191) and its implementing regulations, as amended:

I am Requesting:

____ The electronic patient care report (ePCR) from the Fairbanks Fire Department for the date(s) of service listed above (**this authorization is for records release only, not bills**.)

I understand that the information contained in my health record to be released or disclosed may contain information relating to the treatment of drug and alcohol use/abuse, mental health, acquired immunodeficiency syndrome, or human immunodeficiency virus, sexually transmitted diseases, tuberculosis information, or genetics. I authorize the release or disclosure of this type of information **unless** indicated here: (Signature):_____Date:_____

The purpose(s) of this requested use or disclosure is/are:
_____
(The statement "at the request of the individual" is a sufficient description if the individual does not wish to disclose the purpose)

I understand that even with my authorization, Fairbanks Fire Department shall only release protected health information in accordance with applicable HIPPA law.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer subject to protection under law. The privilege I must Maintain the confidentiality of this PHI is not waived for any other organizations, individuals, or insurance companies not named herein. By affixing my signature below, I acknowledge that I release the City of Fairbanks, Fairbanks Fire Department, agents, and employees from all liability whatsoever in connection with this request to release medical records or information.

This release expires six (6) months from the date below. A photocopy of this release may be used in place of the original.

I understand that this release may be revoked by me at any time in writing. However, any actions taken before that written revocation is received by any party in reliance upon this written release shall not be deemed invalid by reason of such later revocation.

FAIRBANKS FIRE DEPARTMENT

1101 Cushman Street, Fairbanks, AK 99701
(907)450-6600 Fax (907)450-6666
TTY/TTD (800)770-8973 RELAY Alaska
fire@ci.fairbanks.ak.us

I understand that I have a right to receive a copy of this signed written release.

I agree to pay the reasonable cost of copying and mailing associated with this request per the City of Fairbanks policy and as determined by the Fairbanks Fire Department.

SIGNATURE AND VERIFICATION REQUIREMENTS:

I am
____ The patient
____ The parent of the patient, who is under 18 years of age
____ An authorized court-appointed representative of the patient
(Authorized court representative/parent must provide a copy of the appointing document from a court of competent jurisdiction or proof of parental status)

DATED: _____

_____
Signature of Patient/parent/appointed representative

D.O.B. _____

S.S.N.# _____

State of _____, _____ County/Borough. Signed and verified before me on this _____th day of _____, 20___.

_____
Signature of Notary of the State of _____

(Notary Seal)

_____
My Notary Expiration Date

(Notarization required for third party or mail in request)

<u>*For office use only*</u>

In lieu of Notarization, verification requirements may be met by the following:

_____ In-person patient request verified by government-issued identification (copy of ID to be retained with request)

_____ In-person request by authorized third party – parent, legal guardian, or other court-appointed representative verified by government issued photo ID and copy of appointing document (copy to be retained with request)