SIERRA MADRE FIRE DEPARTMENT

242 W. Sierra Madre Blvd., Sierra Madre, CA 91024 | Phone: (626) 355-3611 | Fax: (626) 355-3611

Authorization for Release of Protected Health Information

This authorization for use or disclosure of medical information is in compliance with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et., seq. California Civil Code. Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

Information requested by a patient, parent or legal representative, can only be given to person(s) who present photo identification or by mail, with a letter from a legal representative and/or subpoena.

Incident & Patient Information

Incident Date:_____ Location:_____ Time:_____

Patient Name (First Middle Last):_____

Address of Patient:_____

City:_____ State:_____ Zip Code:_____

Date of Birth of Patient:_____

I request the record to be released in the following manner:

☐ In person ☐ Mail ☐ Fax:_____

Requesting Parties Information

Name of Requestor:_____ Phone:_____

Company/Organization:_____ Email:_____

Address:_____

Relationship to Patient:_____

A copy of the legal authority to make medical decisions for the patient listed on the medical report must accompany this request. If the patient is deceased a copy of the death certificate must be included with request.

By submitting this form, I, _____hereby voluntarily authorize the Sierra Madre Fire Department to release this medical record to the representative noted above.

This authorization shall become effective immediately and shall remain in effect until the date of:_____ _____. Termination shall be 90 days from date signed if not specified herein.

This authorization may be subject to revocation by the authorizing party at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.

I understand that further use or disclosure of this information is prohibited by law unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also understand that the Sierra Madre Fire Department cannot prevent re-disclosure of information by the person or organization who receives the records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

I understand that I have the right to inspect or receive a copy of the information to be used or disclosed.

I am signing tis authorization for the disclosure of health information voluntarily, and treatment, payment or eligibility for benefits will not be affected if I do not sign.

_____	_____	_____
Signature of Patient	Date	CDL#
_____	_____	_____
Signature of Parent or Legal Representative	Date	CDL#
_____	_____	_____
Print Name of Parent or Legal Representative	Date	Phone Number