City of Tacoma Fire Department

Patient Request for Access and/or Authorization To Release Health Care Information (Protected Health Information or PHI) Form

Patient Information:

Name (Please Print full name):_____ Date of Birth:_____
Address:_____
Phone Number:_____ Email Address_____
Date(s) of Service:_____ Location/ Address of Service_____

Release Format:

- ❑ Registered Email (PDF) (Most Secure)
- ❑ Regular Email (PDF) (Not as secure, you release any liability from the Tacoma Fire Department.)
- ❑ Mail (Paper Copy) (Least secure, we are not responsible if documents are lost or stolen.)
- ❑ In-Person (Paper Copy) (We try to provide same day, but we are allowed up to 30 days from the day we receive this form, as stated in our Notice of Privacy Practices.)
- ❑ Verbal/Oral Discussions

To better allow us to process your request, please indicate the type of request you are making on this form (Check all that apply).

- ❑ Access to review my health information.
- ❑ Access to obtain copies of my health information.
- ❑ Access to review and potentially request amendment of my health information.
- ❑ Access to review and potentially request restrictions on the use and disclosure of my health information.
- ❑ Access to health information for someone other than myself.

Send My Information To:

Name/Organization: _____
Phone:_____ Email:_____Fax:_____
Address:_____

Purpose of Release:

- ❑ Health Care
- ❑ Personal
- ❑ Legal/Investigative/Judicial Action
- ❑ Billing
- ❑ Insurance
- ❑ Other_____

What Information should be released: _____
_____

- ❑ Specific Dates of Service or Condition-Related Information:_____
  _____
- ❑ Verbal Communication about my medical history and care: _____
  _____

Please Continue on the back

Special Information:

I authorize the inclusion of the following information with this release *(initial all that apply)*

____ Sexually Transmitted Infections, including HIV/AIDS

____ Substance Use Disorder (SUD) information

____ Psychiatric, mental or behavioral health information.

____ Genetic information and indicators

Note If this section is not completed, records including the above (if they exist), will not be released or will be redacted

Your Rights and Other Notices:

1. As a patient, you have the right to access, copy, or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices.
2. Once TFD releases your health information, the recipient may re-disclose that information, and privacy laws may no longer protect it. Some information, such as substance use disorders or mental health may still be protected.
3. I can withdraw this authorization at any time (please refer to the Revocation section below). If I withdraw my authorization it will not change actions that were already taken according to the authorization.

Expiration:

This authorization is valid for 365 days from the date of signature or until the date or event specified here:

_____

Signature:

Patient/Representative: _____ Date_____

Legal Authority _____ Minor Signature:_____

(Signature of the individual and date) (If co-signature is required for minors. Please see below)

If the authorization is signed by a personal representative of the individual, a description of such representative's legal authority to act for the individual must also be provided in the space above with the documentation described below.

Printed Name and Date_____ Relationship_____

Revocation:

You may revoke this authorization in writing to HIPAA@CityofTacoma.org

Consent for Minor:

A signature of a minor patient is required to release information concerning: (1) treatment for a minor patient aged 13-17, (2) emergency treatment for a minor and a person legally authorized to consent on behalf of the patient not readily available, (3) non-emergency treatment provided to a minor authorized to consent to health care without parental consent, (4) drug or substance use treatment or referral information (for capable minors under 13, both minor and guardian must consent), and (5) mental health treatment information if the minor is 13 or older.

Legal Photo ID is required for records release. For a request of someone else's medical records, please include documentation providing you the legal authority to do so (e.g., power of attorney, birth certificate).

FOR OFFICE USE ONLY

Incident Number:_____ Incident Date(s):_____

- ❑ Privacy officer/designee – authorization to release copy of ePCR
- ❑ ePCR provided

_____ Privacy Officer Approval (if necessary)