



# HUNTINGTON BEACH FIRE DEPARTMENT

2000 Main Street Huntington Beach, CA 92648

Phone (714) 536-5411 Fax (714) 374-1678 Email: Medical.Reports@surfcity-hb.org

## Request for Release of Fire, Medical and/or Marine Safety Records

### SECTION 1: TYPE OF RECORD

**FIRE:**

Incident Report  
Investigation Report  
Photos

**MEDICAL:**

Medical Report  
Billing Invoice

**MARINE SAFETY:**

Medical Report  
Non-Medical Report

### SECTION 2: INCIDENT INFORMATION

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Incident #: \_\_\_\_\_

### SECTION 3: REQUESTOR INFORMATION - ALL APPLICABLE INFORMATION MUST BE PROVIDED

Name/Company: \_\_\_\_\_ Reference #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

To be released via (CHOOSE ONE): Pick up - and if not by Patient, provide Representative's Name: \_\_\_\_\_

US Mail, using address noted above

Fax: \_\_\_\_\_

Email: \_\_\_\_\_ & sign the following statement ONLY for medical record requests:

*I hereby understand and agree that requests for electronic copies of the medical records from the City of Huntington Beach in electronic form via email may not remain confidential due to the unsecured nature of email transmission. I further understand and agree that the City of Huntington Beach, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION 4: PATIENT INFORMATION FOR MEDICAL RECORD REQUEST

Patient Name: \_\_\_\_\_

Requestor Relationship and Document(s) Necessary for Release: **(All submitted documents/IDs must be clear & readable copies)**

Patient (ID) Patient Legal Guardian (legal document, Guardian ID) Subpoena Law Enforcement (Agency ID)

Parent of Minor (legal document, Parent ID, and Parent signs this form) Estate Executor (legal document and ID)

Attorney Representing Patient (letterhead stating representation & HIPAA release signed by Patient or their Parent/Legal Guardian)

Authorized Representative (legal document or patient signs this form; Patient ID & Representative's ID)

### SECTION 5: PATIENT AUTHORIZATION (for self-requests; completed by PATIENT or PARENT/GUARDIAN OF MINOR PATIENT)

*By submitting this form, I hereby voluntarily authorize the City of Huntington Beach to release this medical record. As the patient, the authorization provided herein shall expire immediately after the disclosure and may be used only for the purpose(s) specified herein. I also understand that the person or organization to whom I forward my information may have the legal right to disclose this information to other people or organizations without my knowledge or consent. If you are the parent of a minor and represent as such, you agree to hold harmless the City of Huntington Beach from damages regarding the disclosure. I hereby understand and agree that requests for electronic copies of my medical records from the City of Huntington Beach in electronic form via email may not remain confidential due to the unsecured nature of email transmission. I further understand and agree that the City of Huntington Beach, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system.*

Patient (or Parent/Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have been advised of my right to receive this authorization form **and request a copy of it when the records are released.**

**CHECK ONE:** **No Limitations on the type of information to disclose** **Limited to:** \_\_\_\_\_

#### INTERNAL USE ONLY:

Name/Title of Employee Who Received Request: \_\_\_\_\_ Date: \_\_\_\_\_

Name/Title of Employee Who Approved Request: \_\_\_\_\_ Date: \_\_\_\_\_