ANAHEIM FIRE & RESCUE
201 S. Anaheim Blvd., Suite 300
Anaheim, CA 92805
Office (714) 765-4034
Fax (714) 765-4008

For Office Use Only:

Incident Report #:_____

Number of pages:_____

Information Redacted: [ ]Yes [ ]No

Date report ready:_____

Date Picked Up:_____

$_____Fee Collected

ID verified: [ ] Driver's License
[ ] Work Issued ID
[ ] Passport
[ ] Other:_____

Initials:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:_____

Incident and Patient Information

Name: _____ **DOB:**_____

Fire Incident # (if known):_____

Date of Incident: _____ **Approximate Time:** _____

Location of Incident (specific address or cross streets): _____

_____

1. The following may receive disclosure of protected health information about me:

_____

2. The specific information will not be released unless specifically authorized by the relevant marked box(es) below:
   - ☐ Any and all fire incident reports
   - ☐ Pre Hospital Care Report
   - ☐ Other (must be specific):_____
3. PURPOSE: The purpose of the authorization is at the request of the patient/patient representative.
4. RE-DISCLOSURE: I understand that the information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws.
5. REVOCATION: I may revoke this authorization by notifying you in writing of my desire to revoke it. However, I understand that any action or release of information requested already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions taken.
6. PATIENTS RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and request my medical records be amended as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.
7. EXPIRATION: Unless otherwise revoked, this authorization will expire 12 months after the date of my signing this form below.
8. I understand that release of health information is voluntary.
9. A photocopy of this document shall be deemed as valid as the original.

Printed Name: _____ **Date:** _____

Signature: _____

Telephone # (including area code): _____

Relationship to Patient (patient, parent, guardian, conservator, representative):

_____