# Santa Cruz Fire Department
# Request Form for Fire/EMS Incident Report

I am requesting the Santa Cruz Fire Department record types selected below:

☐ **INCIDENT REPORT.** Report created by the Incident Commander that complies with the rules of the National Fire Incident Reporting System (NFIRS).

☐ **FIRE INVESTIGATION REPORT.** Not all fires will have a Fire Investigation Report. Depending on the incident complexity and other factors a report may not be completed for weeks or months.

☐ **EMS/MEDICAL REPORT.** A patient authorization form is required if report contains confidential medical information and is requested by any party other than the patient or a court ordered subpoena of records. Court Orders do not require additional information, however, patient's MUST provide photo identification before the report can be released. A copy of their photo ID shall be attached to the completed Fire/EMS Incident Request Form.

The information requested below must be completed in full. Requests without the required information will be returned to sender. If you do not have the necessary incident information, you may contact the Santa Cruz Fire Department Administration Office at (831)420.5280 or by email at: dl_fire@cityofsantacruz.com

**Please note:** We try to process requests within 10 working days. The Department may require additional time to process more difficult requests and if so, an estimated time frame will be provided to the requestor.

**Please type or write clearly:**

Requestor Name: _____ Date: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Incident Date: _____ Incident Time: _____

Incident Address: _____

Type of Incident: _____

Reason for Request: _____

_____

Please return this form to:

*Medical report requests: must include this form, a valid HIPAA Authorization and supporting documentation by the patient (if applicable) to:*

Santa Cruz Fire Department
Attn: Records
230 Walnut Ave.
Santa Cruz, CA 95060
Or email to: dl_fire@cityofsantacruz.com

Fire Department Use Only
Incident # _____
Date Received _____
Initials _____

# SANTA CRUZ FIRE DEPARTMENT

## EMS Report Request

Health Insurance Portability and Accountability Act (HIPPA) [45 c.f.r. § 164.500 *et seq.* (2003)]
California Confidentiality of Medical Information Act (CCMIA) [Civil Code § 56 *et seq.]*

### Emergency Medical Service (EMS) Reports

EMS reports are considered confidential medical records, and are protected by privacy laws. Please use the *(Authorization For Release Of Protected Health Information pdf)* form to request the record. A **clear legible** copy of photo identification (drivers license) must accompany and be attached to the request prior to release of the report.

Most third party requests require either a HIPPA authorization signed by the patient or a court order.

The Department may give a report for a deceased individual to the personal representative of the estate with completed *(Authorization For Release of Protected Health Information (pdf)* a copy of the death certificate and court order showing the appointment of the personal representative.

A report may be released to the guardian of a minor (with proof of legal guardianship), a healthcare decision maker (or an individual who is authorized to make health care treatment decisions for the patient. including the parent of a minor or an agent pursuant to a healthcare power of attorney) with completed *(Authorization For Release of Protected Health Information (pdf)*.

Subpoenas from the District Attorney's Office do not require a HIPAA authorization signed by the patient.

**If you are requesting EMS records:**

Complete and submit the *Request Form for Fire/EMS Incident Report* and *Authorization for Release of Protected Health Information Form* by email at dl_fire@cityofsantacruz.com or mail to:
Santa Cruz Fire Department
Attn: Records
230 Walnut Ave.
Santa Cruz, CA 95060
Or email to: dl_fire@cityofsantacruz.com

# SANTA CRUZ FIRE DEPARTMENT

230 Walnut Ave., Santa Cruz CA 95060 (831) 420-5284 • Email: dl_fire@cityofsantacruz.com

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPPA) [45 c.f.r. § 164.500 *et seq*. (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 *et seq.]*.

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

## Patient Information

Patient Name (first middle last): _____

Incident Date: _____ Incident Number (if known): _____

Incident Location: _____

## Requesting Parties Information

Name of Requestor: _____ Phone: _____

Company/Organization: _____ Email: _____

Address: _____

**Relationship to Patient:**

☐ Parent of Minor ☐ Parent of Disabled Adult ☐ Legal Guardian ☐ Beneficiary ☐ Patient Authorized Representative

☐ Executor of Estate ☐ Power of Attorney ☐ Representing Attorney ☐ Law Enforcement ☐ Subpoena ☐ Spouse/Significant other

**You MUST provide a copy of the legal authority you have to make medical decisions for the patient listed on the medical report. If the patient is deceased a copy of the death certificate must be included with request.**

## Format of Record Release

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

☐ In Person ☐ Mail ☐ ☐

Limitation on the Type of Information to Disclose

☐ No limitations on the type of information to disclose ☐ Limited to: _____

## Patient Authorization

By submitting this form, I herby voluntarily authorize the Santa Cruz Fire Department to release this medical record.

As the patient, if I am authorizing the release of my medical record to the representative noted above. I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure.

I also understand that 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. If you are the parent of a minor and represent as such, you agree to hold harmless the Santa Cruz Fire Department from damages regarding the disclosure.

I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used of disclosed.

Patient Signature: _____ Date: _____

Or, Signature from Other/NOT Patient: _____ Date: _____

☐ I have been advised of my right to receive this authorization and request a copy of it when PCR is released.

## Substantiating Information

Please submit the following with your request:

- A clear copy of your Driver's License or DMV-Issued Identification Card whether or not you are the patient. (Exceptions are made for Representing Attorney and Law Enforcement).
- Documentation of legal representation/responsibility if you are not the patient.

**Submit this form to the address/email at the top of this page.**