



# HUNTINGTON BEACH FIRE DEPARTMENT

2000 Main Street • Huntington Beach, CA 92648  
(714) 536-5411 • Fax (714) 374-1678

## Request for Release of Medical Records

### SECTION A: Patient Record Information

Patient Name (first middle last): \_\_\_\_\_

Incident Date: \_\_\_\_\_ Incident Number (if known): \_\_\_\_\_

Incident Location: \_\_\_\_\_

### SECTION B: Record Release Information

#### RECORD WILL BE RELEASED FROM THE HUNTINGTON BEACH FIRE DEPARTMENT

Name of Requestor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company/Organization: \_\_\_\_\_ Email: \_\_\_\_\_

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

Relationship to Patient:  Patient  Parent of Minor  Legal Guardian  Patient Authorized Representative  
 Executor of Estate  Power of Attorney  Representing Attorney  Law Enforcement  Subpoena

### SECTION C: Format of Record Release

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

In Person  Mail (address from Section B)  Fax (fax from Section B)  Email (email from Section B)

### SECTION D: Limitation on the Type of Information to Disclose

No limitations on the type of information to disclose  Limited to: \_\_\_\_\_

### SECTION E: Patient Authorization

By submitting this form, I hereby voluntarily authorize the City of Huntington Beach to release this medical record.

As the patient, if I am authorizing the release of my medical record as noted to the representative as noted in Section B, I understand that the release only pertains to the disclosure of the record described herein. 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 who receives my information because of this authorization 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.

Please provide a general description of the purpose for the requested release: \_\_\_\_\_

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 the record is released.

### SECTION F: Substantiating Information

Please submit the following with your request: (Submit the request in person or to the address/fax at the top of this page)

- A **clear** and **readable** 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 requesting the record

### Internal Use Only

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

Name and Title of Employee Who Approved Release: \_\_\_\_\_ Date: \_\_\_\_\_