Community Fire Protection District

Request for Incident Report with Patient Health Information

This form is for Fire & EMS reports containing PHI only, which require Privacy Officer review. Fire reports not containing PHI may be obtained online or through administrative offices.

PATIENT DETAILS

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone: _____

INCIDENT DETAILS

Date of Service: _____ Incident # (if known): _____

Address of Call: _____

INFORMATION REQUESTED (Check all that apply)

☐ Fire Incident Report (with Unredacted PHI)
$25.00 fee applies

☐ EMS Patient Care Report
$30.00 fee applies

Do you require a notarized affidavit? ☐ YES ☐ NO

Do you require a billing statement? ☐ YES ☐ NO

This form is for Fire & EMS reports containing PHI only, which require Privacy Officer review.

This form must be accompanied with a completed Authorization for Release of Medical Record Information.

Attorneys Requesting Report

Please also include your request on official letterhead with patient's signed release of records statement.

Authorization for Release of Medical Record Information

Please complete this form and mail or present to:

Community Fire Protection District
Attn: Medical Records
9411 Marlowe Avenue
St. Louis, MO 63114

or email the completed form to cmeier@communityfpd.org

Patient Information

Patient Last Name		**First Name**		**MI**	
Street Address				**Apt #**	
City		**State**		**Zip**	
Patient Number#		**Home Telephone**	( )		
Date of Birth		**Alternate Telephone**	( )		

Community Fire Protection District has my permission to release information contained in the Medical Record of the above-named patient.

Information Requested (please be specific and enter date of service if known):
PATIENT CARE REPORT

Restrictions and/or Exclusions (if any):

Purpose of Release:

Community Fire Protection District will provide the information requested above to the following party:

Name					
Attention of		**Telephone**	( )		
Street Address		**Suite/Room**			
City		**State**		**Zip**	

I hereby authorize Community Fire Protection District to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Community Fire Protection District cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Community Fire Protection District may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Community Fire Protection District has relied upon it. For example, if I cancel it after Community Fire Protection District has sent requested records, Community Fire Protection District will not retrieve those records. Instructions for canceling this authorization are included in the Community Fire Protection District Notice of Privacy Practices.

I understand that Community Fire Protection District will continue to provide care, even if I do not authorize this release.

Signature of Patient (if 18 years of age or older)		**Date**
Signature of Parent or Guardian (if minor patient)	**Relationship to Patient**	**Date**

Please make a copy of this release for your records.