FIRE / RESCUE REPORT REQUEST

Name of Person/Company Requesting Report_____

Phone Number _____

REPORT REQUESTED FIRE _____ RESCUE _____

Incident Related Information:

CCR# _____ Date of Incident _____ Time of Incident _____

Name_____ Address of Incident_____

Description of Incident _____

_____

For Rescue Report release if other than patient (guardian), please attach a Medical Authorization or Subpoena.

Fee for Report Release:

Fire Reports $3.00 Rescue Reports $5.00

Please attach a stamped, self-addressed envelope and report will be mailed within 48 hours if all above information is included.

For office use only:

Report released by _____ Date _____

Receipt Number _____

FIRE AND RESCUE DEPARTMENT

Patient Request for Access Form
EMS / Patient Care Report

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____ Date of Birth _____

Date of Service: _____ Location of Incident _____

If Patient Health Information is to be released to someone other than Patient, please complete the following:

Name of Person/Company Requesting Report: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number of Requesting Person/Company: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies which you may have upon request.

To better allow us to process your request, please indicate the type of request you are making on this form: [check all that apply]

_____ Access to simply review my health information.

_____ Access to obtain copies of my health information.

_____ Access to obtain copies of an itemized bill for services

_____ Access to review and potentially request amendment of my health information.

_____ Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

_____ Access to review and potentially request restrictions on the use and disclosure of my health information.

Patient Signature _____ *Request Date* _____

Responsible Party Signature _____ *Date* _____

515 N. Julia Street . Jacksonville, Florida 32202-4128 . (904) 630-0434 . FAX (904) 630-4202

***The fee for a patient health information record is $5.00 (each record) per City of Jacksonville, Ordinance Code 94-624-487.**

For JFRD Use Only:
Report released by: _____ Date:_____

Receipt Number: _____

Mail / Fax this form to:

Jacksonville Fire & Rescue Department
515 N. Julia St.
Jacksonville, FL 32202
Voice – 904-630-0382
Fax – 904-630-4202

You must enclose:

1. Clear photocopies of two forms of picture identification (One must be a state drivers license or state identification card)
2. Self addressed stamped envelope
3. Check or money order for $5.00 made payable to City of Jacksonville Tax Collector
4. This completed form

Note:

For information to be return mailed, information provided on this form must match the information documented on the patient care record. Further justification and identification may be required in addition to requiring that said records be picked up in person.

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