Central Pierce Fire & Rescue
Mailing Address: PO Box 940 Spanaway, WA 98387
District Headquarters: 1015 39th Ave #120 Puyallup, WA 98372
P: (253) 538-6400 | F: (253) 276-6770 | records@centralpiercefire.org

REQUEST FOR PATIENT CARE RECORDS

Identification of Records:

Location/Address of Incident: _____
Date of Incident: _____
*** If the date is unknown, please provide an approximate date range. ***
Patient: Last _____ First _____ MI _____ DOB _____

Requestor Information: *** A photo ID of the requestor is required to complete the request.***

Name: Last _____ First _____
Company: _____ Phone: _____
Email: _____ Fax: _____
Mailing Address: _____
Relation to Patient:

☐ Self ☐ Attorney/Legal ☐ Personal Representative

☐ Guardian ☐ Media ☐ Other Agency (i.e., Police, DSHS, Fire Marshal)

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information (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 District policies, which you may have upon request. I understand that I have the right to revoke this Authorization at any time except to the extent that CPFR has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the District Privacy Officer.
I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections by law. I understand that my written authorization is not required to use my PHI for treatment, payment and health care operations. I understand that I have the right to inspect and copy my PHI. The Authorization is being requested for the following purposes:

_____

By signing this form, I hereby authorize and direct the use or disclosure by Central Pierce Fire & Rescue of certain medical information (PHI) pertaining to my health, my health care, or me. I acknowledge that I have read the provisions in this form and that I have the right to refuse to sign this form. I understand and agree to its terms.

Date of Request: _____ **Patient Signature:** _____

***** This authorization will expire 90 days from the date the request is signed. *****

For Official Use Only

Date Processed: _____ Incident #: _____ HIPAA Compliant ☐

☐ Request granted ☐ Record withheld ☐ Record withheld in part ☐ No records found

Delivered via:

☐ Secure Email ☐ Secure Portal ☐ Mail ☐ Pick-up ☐ Fax

Amount Paid: _____ Receipt #: _____ ☐ Cash ☐ Check: _____

Processed by: _____ Approved by: _____