Harrison Township Fire Department

Release of Medical Records Application

Form # 1000.90

Chief Shawn C. Davidson
3625 S.R. 752
Ashville, Ohio 43103
(740) 983-4115 *(p)*
(740) 983-8114 *(f)*

This form is intended for use by patients or patient representatives who wish to obtain a copy of medical records including patient care reports. This form must be completed in its entirety, notarized and you must present a valid form of identification before any records will be released. Your identification will be copied and stored with this application.

This form is not intend for use by attorneys, or any person or group providing legal representation to a patient. Attorneys and law firms must submit their own release signed by their client to the Harrison Township Fire Department, or obtain a subpoena from the court having jurisdiction over their case. Additionally, this form is not intended for use by law enforcement agencies to obtain medical records. Law enforcement agencies shall present a subpoena from the court before records will be released. Refer to Standard Operating Procedure 200.48 – Releasing Protected Health Information for additional information on attorneys and law enforcement obtaining medical records.

Medical records are released free of charge to the patient or patient representative. The Fire Chief and the Medical Director have final decision-making authority of whether any records will be released. If any portion of this form does not apply, write N/A or DNA on that line. If this form is incomplete or vague, your application request will be denied.

Which situation applies to you? (check one box only)

- ☐ I am a patient who received emergency medical evaluation, treatment and/or transport by the Harrison Township Fire Department.
- ☐ I am a patient representative (parent, legal guardian, power of attorney, etc.) who is legally responsible for management of another person's healthcare for which that person received emergency medical evaluation, treatment and/or transport by the Harrison Township Fire Department
- ☐ I am the executor of an estate which belongs to a patient, whom of which is deceased, in which the Harrison Township Fire Department furnished care and/or emergency medical services to the deceased.

PATIENT'S INFORMATION

The following section is about the patient who any medical records pertain to. It is important this section is completed as accurately as possible so that the correct record is located within our records management system. If you are a patient representative seeking records on behalf of another person, DO NOT put your personal information here. Use the Patient Representative section along with this section about the patient you represent.

Patient's Name: _____ (First) _____ (M.I.) _____ (Last)

Patient's DOB (mm/dd/yyyy): _____ Date (or range) Service Was Provided: _____

Address where the patient was located at time service was provided: _____

Approximate time EMS contacted the patient: _____

Was the patient transported to the hospital? ☐ Yes If yes, which hospital? _____

☐ No

Phone number the patient can be reached at: _____

PATIENT REPRESENTATIVE INFORMATION

The following section is about any representative of a patient who is obtaining a record on behalf of the patient. Information provided here must match your government issued identification.

Name: _____ (First) _____ (M.I.) _____ (Last)

DOB (mm/dd/yyyy): _____ Phone number you can be reached at: _____

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Address where you reside: _____

Representative type (check one box only):

- ☐ Parent or Legal Guardian
- ☐ Power of Attorney
- ☐ Executor of Estate

ADDITIONAL INFORMATION

Please provide a brief explanation of why you are seeking copies of protected health information.

_____

_____

_____

AUTHORIZATION

This form must be notarized to be accepted. Do not sign it until you are in the presence of a notary.
Initial the following statements affirming that you know and understand the conditions related to the release of protected health information.

_____ I affirm that I am the patient, parent, legal guardian or patient representative who has been given authority by the patient to conduct the management of the patient's affairs including medical care management.

_____ I acknowledge and accept that, if my application is approved, I am solely responsible for the security, or destruction of the protected health information I am given.

_____ I release the Harrison Township Fire Department of any liability should I or the patient I am representing suffer any damages as a result of not ensuring the security of the records I receive.

_____ I acknowledge, accept and authorize the Harrison Township Fire Department to verify and validate my claim as an executor of estate or power of attorney. This includes, but is not limited to contacting the patient directly, contacting the law firm or legal counsel who assisted in drafting the patient's will or other legally binding documents, or requesting records from the court having jurisdiction.

_____ _____ _____ _____

Signature of Patient | Date | Signature of Patient Representative | Date

ACKNOWLEDGEMENT CERTIFICATE

State of Ohio, County of _____

The foregoing instrument was acknowledged before me on this _____ (date) by

_____ (name of person acknowledging).

Notary Seal

_____

Signature of Notary Public – State of Ohio

My commission expires: _____

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ADMINISTRATIVE USE ONLY

This section is for Fire Department administrative use only. Any writing in this section by a patient or patient representative will result in your request being denied and you will be required to complete a new application.

- ☐ All fields and boxes on this form are completed by the individual requesting PHI.
- ☐ This form has been notarized.
- ☐ This form has been signed by the patient in which the records in question pertain to.
- ☐ This form has been signed by the patient representative requesting records on behalf of the patient.
- ☐ The patient representative presented valid, legal documents corroborating their position as POA or Executor.
- ☐ The person completing this form presented a valid form of government issued identification. Check one below:
  - ☐ State Issued ID card State: _____ Expiration Date: _____ ID #: _____
  - ☐ State Issued Driver's License State: _____ Expiration Date: _____ ID #: _____
  - ☐ United States Passport Booklet/Card Expiration Date: _____ Passport #: _____
  - ☐ United States Green Card Expiration Date: _____ USCIS #: _____
- ☐ The identification presented was copied and attached to this application.
- ☐ The legal documents supporting and identifying a POA/Executor were copied and attached to this application.

This application for the release of protected health information is: ☐ APPROVED ☐ DENIED

Reason for Denial: ☐ N/A _____

Incident/Run #: _____ Date of Service: _____ Date PHI record was accessed: _____

Person who retrieved the PHI record: _____ Signature: _____

Medical Director Notification Date: _____ Contact Method: _____

Signatures (All applications must be signed by the Fire Chief regardless of approval status)

_____ _____
Shawn C. Davidson, Fire Chief Date

_____ _____
Robert Wall, Lieutenant /EMS Coordinator Date

_____ _____
Danni Schneider, Medical Director Date