City of Hollywood Fire Rescue Department
Request and Authorization for Disclosure of Health Information Form
Mail to: 2741 Stirling Road, 3rd Floor, Hollywood Fl. 33312
(954) 967- 4248 http://www.hollywoodfl.org

Please process my request for Medical Record or other (specify) _____. In order to promptly fulfill your request, provide us with the information listed herein: a copy of the applicant's government issued photo ID, if applicable, a Power of Attorney, Healthcare Surrogate documentation, Birth Certificate, and Death Certificate.

ATTORNEYS ONLY: For **ALL** medical record(s) and itemized bill(s) request, register at www.Chartswap.com or to follow-up on medical record(s) or itemized bill(s) request call 1-888-317-2914.

REQUESTING PARTY'S INFORMATION
Name _____
Date of Request ____/____/____
Address_____ Apt./Suite #_____ City_____ State_____ Zip Code_____
Phone Number (_____) _____-_____
PATIENT INFORMATION
Name on Report _____
Patient Date of Birth ____/____/_____, Patient SSN ____-____-____
Location of Incident_____Date of Incident _____/_____/_____
Time of Incident _____ Incident Number (if known) _____

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a patient has the right to access, inspect and copy their Protected Health Information (PHI) maintained by Hollywood Fire-Rescue. Additionally, your rights allow you to request a copy, request to amend and/or request restriction of the use of any disclosure of your (PHI).

This is an authorization requesting the City of Hollywood Fire-Rescue Department to release medical reports and/or information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or by state law protecting the privacy of health information.
I_____ hereby authorize the use and disclosure of the individually identifiable health information to be furnished to the requesting party below.

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

_____ _____
Signature of Patient or Personal Representative Print Name

Relationship to Patient _____

STATE OF _____

COUNTY OF_____

The foregoing instrument was acknowledged before me this _____ day of _____, 20 _____.
By _____.
Personally known __or Produced Identification __ Type of Identification Produced_____
(NOTARY SEAL)

_____
Notary Public