OXNARD FIRE DEPARTMENT
360 West Second Street • Oxnard, CA 93030
(805) 385-7722 • Fax (805) 385-8009

CITY OF OXNARD CALIFORNIA

AUTHORIZATION TO RELEASE PRE-HOSPITAL MEDICAL RECORDS

Oxnard Fire Department (OFD) Pre-Hospital Medical Release

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 CFR § 164.500 et seq. (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 et seq.].

Please review carefully and complete the authorization. Failure to provide all of the requested information may invalidate the authorization.

If you have any questions about this authorization, please contact Fire Administration, Oxnard Fire Department, 360 West Second Street, Oxnard, California 93030, (805) 385-7722.

PLEASE PRINT LEGIBLY

I,_____, hereby authorize Oxnard Fire Department (OFD) to disclose the pre-hospital medical records of

Patient's Name: _____
First MI Last aka

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Patient's Date of Birth: _____ **Phone:** _____

Information to be Released: _____

To be released to (select one): ❑ myself or ❑ my personal representative

Incident Date: _____ **Incident Time** (if known): _____

Incident No. (assigned by OFD, not by the CHP/police): _____

Address/Location, with nearest cross street (if known): _____

_____

The disclosure of information and records authorized herein is required for the following purpose:

❑ Continuation of medical care
❑ Disability/social security determination
❑ Insurance purposes
❑ Immediate patient care
❑ Other: _____
❑ Payment for services
❑ Legal
❑ Personal Use

- I understand that I have the right to a photocopy of this release form.
  Copy requested: ❑ Yes ❑ No

AUTHORIZATION TO RELEASE PRE-HOSPITAL MEDICAL RECORDS

Oxnard Fire Department (OFD) Pre-Hospital Medical Release
(continued)

EXPIRATION
This authorization shall be in force and effect until _____ at which time this authorization to disclose these pre-hospital medical records expires.

PATIENT'S RIGHTS
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the EMS Coordinator at Oxnard Fire Department, 360 W. Second Street, Oxnard, California 93030. I understand that a revocation is not effective to the extent that OFD has relied on the use or disclosure of the protected health information.

OFD will not condition my treatment on whether I provide authorization for the requested use or disclosure, unless as otherwise specifically allowed by law.

I understand that California law prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law. However, if the recipient of my health information is not located in California, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law or by the law of the state in which the recipient is located.

I understand that I have a right to receive a copy of this authorization upon my request. In addition, if OFD has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

With my signature below I hereby authorize the Oxnard Fire Department to release pre-hospital medical records to myself or personal representative according to the Civil Code Section 56.10 and Health and Safety Code Section 123110.

SIGNATURE

_____ Date: _____
Signature of Patient or Personal Representative (month/day/year)

_____
Print Name of Patient or Personal Representative

_____: *Initials* of Fire Administration Employee that **verified Identification** and **provided a copy** of the Release of Pre-Hospital Medical Records.

NOTE: If signed by a Personal Representative of the Patient, please complete the *Affidavit In Support of Request for OFD Pre-Hospital Medical Records* on page 3:

AUTHORIZATION TO RELEASE PRE-HOSPITAL MEDICAL RECORDS

AFFIDAVIT IN SUPPORT OF REQUEST FOR OFD PRE-HOSPITAL MEDICAL RECORDS

I, _____, DECLARE AS FOLLOWS:

1. I am the personal representative of _____
   (name of person whose records you are seeking)
2. The authority for me to act in that capacity is as follows [**please provide a copy of any available document(s) which grants you authority to request the subject records**]:
   - ❑ I am the legal guardian.
   - ❑ I am acting pursuant to a durable power of attorney.
   - ❑ I am the conservator of the person.
   - ❑ I am the executor of the estate of the person whose records are sought.
   - ❑ Other (please describe): _____

     _____
3. If the records are of a decedent, at least 40 days have elapsed since the death of the decedent, and no proceeding is now being or has been conducted for administration of the decedent's estate.
4. On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS.
5. The foregoing is true and correct of my own personal knowledge.

Signature of legally authorized representative (Must furnish proof)

_____ Date: _____
Signature of Personal Representative (month/day/year)

_____
Print Name of Personal Representative

If signed by anyone other than parent of minor, provide copies of appointment papers or durable power of attorney authorizing signature on behalf of patient.

_____: *Initials* of Fire Administration Employee that **verified Identification** and **provided a copy** of the Release of Pre-Hospital Medical Records.