BURBANK FIRE DEPARTMENT

311 East Orange Grove Avenue, Burbank CA 91502 818-238-3473 Fax 818-238-3479

Authorization for Release of Protected Health Information

I, _____ , hereby request to inspect the

Print Your Name

Protected Health Information pertaining to the patient and incident listed below.

NOTE: There will be a charge of $15.00 for record research and materials. This must be paid at the time of the request.

Patient's First Name:	Patient's Last Name:
Incident Date:	Incident Time:
Incident Address:	
Requestor's Phone Number:	Requestor's Email Address:
Purpose for the use or disclosure (for example, personal or legal):	
Date or event upon which you wish this authorization to expire:	
☐ Emergency Medical Services Records ☐ Other:	

IF YOU ARE NOT THE PATIENT, COMPLETE THE FOLLOWING

If you are an authorized representative, provide a copy of your authorization to act on the patient's behalf.	
Authorized Representative's First Name:	Authorized Representative's Last Name:

You may revoke or withdraw this authorization, in writing, by submitting a revocation to the Burbank Fire Department, except to the extent that the Burbank Fire Department has already used or disclosed the requested protected health information in reliance upon this authorization.

You are entitled to a copy of this authorization.

Please note that you will receive a response within 10 days. The Burbank Fire Department/City of Burbank will evaluate your request then either grant or deny it. If the request is granted, please do one of the following:

☐ Contact me and I will pick up the records.

☐ Mail the records to this address: _____

_____ _____

Signature of Patient or Authorized Representative Date

For Office Use Only
☐ *Copy of Patient's ID or Authorized Representative's Documentation*
☐ *Copy of Authorization provided to the Patient or Authorized Representative, if requested*
☐ *Paid*