ENUMCLAW FIRE DEPARTMENT

1330 Wells Street Enumclaw, WA 98022
Telephone (360) 825-5544 Fax: (253) 856-6541
www.enumclawfire.org – EFD@enumclawfire.org

PUBLIC RECORDS REQUEST – INCIDENT REPORT

Date Submitted: _____

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-Mail Address: _____

Date of Incident: _____ Location: _____

Incident #: _____ Name of Party Involved: _____ Date of Birth: _____

Description of Record: Please describe the records you are requesting and any additional information that will help us locate the record for you as quickly as possible. Failure to provide information sufficient to identify the records may cause delay.

I understand any fees associated with the records request will be charged according to the District's Fee Resolution and must be received before the records are released. A 10% deposit may be required for larger requests.

☐ I wish to make an appointment to review the records indicated above before copies are made.

☐ I wish to have copies/duplicates of the records indicated above.
☐ Pick-Up ☐ Emailed ☐ Mailed

I authorize Enumclaw Fire Department to release all medical information regarding the above incident.
☐ I am the party involved ☐ I am the guardian of the party involved ☐ HIPPA Authorization Form Attached

Signature: _____ Date: _____

Witnessed by: _____ Date: _____ Picture ID Checked: ☐ Yes ☐ No

OFFICE USE ONLY:
Response Time: A copy of this form serves as the District's initial response to your request for records. The District estimates that it will take approximately _____ days to respond to your request.

Received by:_____Date:_____

Records released by:_____Date:_____

Amount Paid:_____

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person (or facility or company) may receive disclosure of protected health information about me:

   Name

   Address

   City, State Zip Code

2. The specific information that should be disclosed is (please give dates of service if possible):

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION Patient Signature: _____
   NO, **DO NOT** DISCLOSE THIS INFORMATION

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Enumclaw Fire Department in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____
6. This authorization expires on _____ OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the individual or other signator.

Office Use Only

Received By	**Processed By**	**Log #**