City of Walla Walla

FIRE DEPARTMENT / AMBULANCE

Please fax records request to: (509)524-7906

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please Print Patient Name _____

Date of Birth of Patient _____

Approximate Date(s) of Call/Treatment: _____

I request and hereby authorize The City of Walla Walla – Fire/Ambulance Department to release the following medical information:

- ☐ Ambulance care report
- ☐ Ambulance Bills

Where do records need to go?

_____

Please Print Name of Individual or Agency Requesting Records

_____

Mailing address

_____(____)_____

City, State, Zip Code **Phone Number**

Health records needed for the purpose of:

☐ Personal Files ☐ To process insurance claims ☐Other: (Please indicate.) _____

Permission to fax:

☐ Yes, I want my records faxed to (_____) _____ Please provide initials: _____

☐ No; I do not want my records faxed.

Permission to send confidential health records electronically through the internet via e-mail. Please note before choosing.

PUBLIC DISCLOSURE NOTICE TO RECIPIENT(S): Information contained in any communication to or from the City of Walla Walla, including attachments, may be subject to the disclosure requirements of Washington's Public Records Act, Ch. 42.56 RCW.

☐ Yes, I want records to be emailed to address: _____Please provide initials: _____

☐ No, I don't want my records sent electronically.

This authorization to release protected healthcare information will expire within 90 days from time of signature. I may revoke this authorization in writing at any time, provided that the information has not yet been released. To view the process for revoking this authorization, please read the Privacy Notice. I understand that once the City of Walla Walla – Fire Department discloses health information, the person, or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws. **I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic information. I give my specific authorization for these records to be released. OR Exclude the following information from the records released.**

Initial each that should not be released: ___ Drug/Alcohol abuse/treatment & diagnosis ___ Sexually Transmitted Disease ___ Genetic Information ___ HIV/AIDS diagnosis/treatment/testing ___ Mental Illness or Psychiatric Diagnosis/Treatment

_____ _____ _____

Signature **Printed Name of who signed.** **Date**

Signer is ☐ Self ☐Parent ☐ *Legal Guardian ☐ *Authorized Representative **(*Please provide documents to prove authority to sign on behalf of the patient.)**

Walla Walla Fire/EMS Department office use only

Request received on: _____ If in person, was ID Checked? ☐ Yes ☐ No- Reason _____

Call #(s) _____

The following records were ☐ Mailed ☐ Faxed (Keep copy of fax face sheet and confirm sheet.) ☐ Given in person ☐ emailed

☐ Copy of Ambulance report with attachments ☐ Copy of CMS1500 claim ☐ Copy of Patient Billing ☐ Other: _____

Records request completed by: _____ on _____

Employee Date

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