



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 Billing . 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.

This form is not for attorney use: Attorneys for medical record(s) and itemized bill(s) mail request on letterhead with HIPAA release or by subpoena to City of Hollywood Fire/Rescue, Attn: Medical Records Custodian, 2741 Stirling Road, Hollywood, FL., 33312-6505. For Everyone: billing disputes, statements or hardship call: 1-888-980-9237/1-888-317-2914 or email: ClientSupportServicesMIA@digitechcomputer.com.

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.

_____ 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