Ventura County Fire Protection District
Attn: Custodian of Records Office
2400 Conejo Spectrum Street, Thousand Oaks, CA 91320
(805) 383-4718 or firepublicrecords@ventura.org

REQUEST FOR EMERGENCY RESPONSE RECORDS WITH MEDICAL INFORMATION

The Ventura County Fire Protection District (VCFPD) makes every effort to comply with requests for public records under the California Public Records Act while ensuring compliance to Federal (HIPAA) and State (CMIA) Laws for Protected Health Information (PHI). A fee may be required.

The attached Authorization for Use & Disclosure of Protected Health Information and Records form must be fully executed and provided along with this request by U.S. MAIL, in person, or secure email before records are searched for and provided.

Please search and if available provide the Fire District record types highlighted below:

- ☐ **INCIDENT REPORT**. Report created by the Incident Commander that complies with the rules of the National Fire Incident Reporting System (NFIRS).
- ☐ **INCIDENT DETAIL REPORT**. Report that captures incident events with time stamps that are reported into the Dispatchers Log (CAD) during the incident.
- ☐ **FIRE INVESTIGATION REPORT**. Not all fires will have a Fire Investigation Report. Depending on the incident complexity and other factors, a report may not be completed for weeks or months.
- ☐ **MEDICAL REPORT**. Not all responses will have a medical report created by a Fire Responder.
- ☐ **OTHER**. Please search for the following: _____

_____

INCIDENT INFORMATION *(*required field)*

Incident Number (if known; assigned by VCFPD, not by law enforcement): ☐☐ - ☐☐☐☐☐☐☐

Date*: _____ Address/Location*: _____

City/Community*: _____ Cross Street (if known): _____

Time (estimate): _____ Incident Type (fire, accident, etc.): _____

REQUESTER INFORMATION

Requester: _____ Phone: _____ Mobile: _____

Email: _____ Mailing Address: _____

SUBMISSION IS ONLY BY U.S. MAIL OR IN PERSON AT FIRE HQ: 2400 Conejo Spectrum Street, Thousand Oaks, CA 91320 OR VIA SECURE EMAIL: firepublicrecords@ventura.org

(If emailing this form and supporting documents, please check with your email provider for how to send confidential emails.)

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

Ventura County Fire Protection District (VCFPD) 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 c.f.r. § 164.500 *et seq*. (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 *et seq*.].

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

If you have any questions about this authorization, please contact the Custodian of Records, Ventura County Fire Protection District, 2400 Conejo Spectrum Street, Thousand Oaks, California 91320, (805) 383-4718.

RECORDS TO BE RELEASED

I, _____ hereby authorize Ventura County Fire Protection District (VCFPD) to disclose the protected health information and records of:

PATIENT INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Street Address: _____ City/State/Zip: _____

INDIVIDUAL AUTHORIZED TO RECEIVE THE INFORMATION *(**Name must match name under Requester Information on page 1.)*

Name: _____ Organization: _____

Relationship to Patient: _____ Phone: _____

Street Address: _____ City/State/Zip: _____

AUTHORIZATION EXPIRATION DATE *(must be completed to receive records)*

Unless otherwise revoked by the patient, this authorization for the release of protected health information to the above-named individual/organization will expire on the date specified below:

Date of Expiration: _____
(month/day/year)

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

Ventura County Fire Protection District (VCFPD) Medical Release (Continued)

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 Records Department at Ventura County Fire Protection District, 2400 Conejo Spectrum Street, Thousand Oaks, California 91350. I understand that a revocation is not effective to the extent that VCFPD has relied on the use or disclosure of the protected health information.

VCFPD 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 VCFPD has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one.

PATIENT SIGNATURE

_____ Date: _____

Signature of Patient (month/day/year)

_____

Print Name of Patient

SIGNATURE OF REQUESTER, IF NOT PATIENT *(**Name must match name under Requester Information on page 1.)*

_____ Date: _____

Signature of Personal Representative (month/day/year)

_____

Print Name of Personal Representative

NOTE: If signed by a Personal Representative of the Patient, please complete the *Affidavit in Support of Request for VCFPD Medical Records* on next page.

Office Use Only

_____ Initials of VCFPD Custodian of Records that a copy of the release was provided.

AFFIDAVIT IN SUPPORT OF REQUEST FOR VCFPD MEDICAL RECORDS

NOTE: This page to be filled out only if you are not the person whose records you are seeking and you have authority to request the subject records. Must provide supporting documents.

I, _____ DECLARE AS FOLLOWS:

1. I am the personal representative or beneficiary of _____
   (name of person whose records you are seeking)
2. The authority for me to act in that capacity is as follows **(Must provide a copy of documents you have that 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 & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS.
5. The foregoing is true and correct of my own personal knowledge.

I declare under penalty of perjury that the foregoing is true and correct. Executed at:

_____ Date: _____
(city, state) (month/day/year)

_____ _____
Print Name Signature