Charlottesville Fire Department

Upon completion of this form, it may be scanned and emailed to emsbilling@charlottesville.org

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Social Security # or Patient ID

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

Type of Request

- ☐ Access/copy
- ☐ Confidential communication
- ☐ Amendment
- ☐ Accounting of disclosures
- ☐ Restriction
- ☐ Complaint

As the person signing this consent, I understand that I am giving my permission to the Charlottesville Fire Department for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the person or agencies to whom disclosure was made shall be included with my original records. **The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.**

Please list Charlottesville Fire Department staff members contacted regarding this matter:

Name — Date

Name — Date

Signature — Date

For Administrative Use Only: — Date received

Action taken — Date

Action taken — Date

Privacy Official signature — Date

Records Release for Deceased or Mentally Incapacitated Patient – see reverse

Attach additional documentation, if applicable.

Records Release for Deceased or Mentally Incapacitated Patient

If records are those of a deceased or mentally incapacitated patient:

First: to the personal representative or executor of the deceased patient or the legal guardian or committee of the incompetent or incapacitated patient

Second: If there is no personal representative, executor, legal guardian or committee appointed, to the following persons **in the following order of priority**: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased patient in order of blood relationship

I certify that I am entitled to receive the requested record on the front of this form because the patient is deceased or incapacitated and there is no other person of higher priority (as set forth in the above paragraph) that is entitled to receive the record.

_____ _____

Signature of requesting party Date

_____ _____

Printed Name of requesting party Relationship to patient

For Administrative Use Only:

_____ _____

Date received

Action taken _____ _____

Date

_____

Action taken _____ _____

Date

_____

_____ _____

Privacy Official signature Date