

West Barnstable Fire District

HIPAA Medical Records Release Form

Date:

Patient information will only be provided to the patient or their legal representative

Your Name _____ Date of Birth _____

Patient Type:

Self _____ MinorName _____ Guardian _____

Date of Service:

Medical Records _____ OTHER _____

Record Release - Records to be released to the following individual:

Name _____

Address _____ Email Address _____

Phone Number _____ Fax _____

Delivery Method – Tell us how you would like to get this information.

U.S. Mail _____ Request Completed by _____

Fax _____ Request Completion Date _____

Email _____ Requestor Contacted _____ Picked up _____

MEDICAL DISCLAIMER: I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and /or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

ADDITIONAL MEDICAL DISCLAIMER

By checking here you agree to abide by the Terms of Service outlined above.

Sept 4, 2019