The Village of Woodmere
Department of Public Safety
Division of Emergency Medical Service / Fire
Medical Records Request and Authorization to Use and Disclose Specific Protected Health Information (PHI) Form

Instructions: This is an interactive form with the exception of the areas that require a signature and the Notary Section at the end. This form is to be filled out completely and no blank spaces. This form can be filled in online and then printed or printed then filled in. In order to process a request, the completed and notarized form along with a $7.00 fee (check or money order) per patient/per date must be submitted to:

The Village of Woodmere Fire Department
Department of Public Safety
Division of Emergency Medical Service / Fire
27899 Chagrin Boulevard
Woodmere Village, Ohio 44122

Checks and Money Orders can be made payable to: The Village of Woodmere Fire Department

ALL INFORMATION/BLANK SPACES MUST BE FILLED IN FOR VALID AUTHORIZATION (USE N/A IF APPROPRIATE)

Requestor Information

Name of Requestor: _____

Relationship to Patient: _____

Firm Name: _____
(If requestor is an Attorney, otherwise use "N/A")

Requestor's Address: _____

City: _____ State: _____ Zip Code: _____

Requestor's Phone Number: _____

Requestor's Signature: _____ Date: _____

Authorization By Patient or Parent/Legal Guardian To Disclose PHI To Requestor

By signing this Authorization, I,_____, hereby authorize the disclosure to the above Requestor by The Village of Woodmere of certain medical information pertaining to the health, health care of:

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Service: _____

Location of Service: _____

Relationship to Patient: _____

This Authorization is for the release of the following medical information about the above name patient (check all that apply)

- o Patient Care Run Report
- o Billing Statement
- o Diagnostic Procedures
- o Other:

(Must be specific)

This information may be used by The Village of Woodmere and may be disclosed to:

(List names or identification of person(s) or class of persons to whom the described medical information is to be disclosed)

This information is being used or disclosed for the following Purpose(s):

(State specific purpose(s) or "By the request of the patient")

This Authorization shall be in forced and effect until (specify date or event):

I understand that I have the right to revoke this Authorization at any time, except to the extent that The Village of Woodmere has already acted in reliance on the Authorization prior to the above expiration date or time, I understand that I must do so by written request to The Village of Woodmere EMS Contact/Privacy Officer (Lieutenant S. Latif Ibn Ali I., Woodmere Fire, 27899 Chagrin Boulevard, Woodmere, Ohio 44122, phone number 216-292-4103).

I understand that information used or disclosed pursuant to this Authorization may be subjected to re-disclosure by the recipient and no longer subjected to privacy protections provided by law. I understand that this information may be hand-delivered, mailed, faxed or verbalized, dependent upon the circumstances of the request.

I understand that my written authorization is not required for The Village of Woodmere to use my protected health information for treatment, payment and health care operations. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.

I acknowledge that I have read the provisions in this Authorization and that I have the right to refuse to sign this authorization. I understand and agree to its terms.

IMPORTANT

<u>The remainder of this form MUST be signed by the Patient, or, if a minor, his/her authorized parent or legal guardian, in the presence of a Notary Public.</u>

Print name _____ Print Title: _____
(*Patient or Parent / Legal Guardian)*

Signature _____ Date:_____

State of:_____**)**
) SS: Affix Seal
)
County of : _____

Subscribed to and sworn before me this _____ day of _____, 20_____

by_____.

Notary Public_____

Signature:_____

My Commission Expires On:_____