ELIZABETH FIRE PROTECTION DISTRICT
OPEN RECORDS REQUEST FORM

NOTICE: The Elizabeth Fire Protection District (EFPD) has adopted a *Standard Operating Procedure for Open Records Requests* ("*Policy*"), a copy of which may be obtained from EFPD's administrative offices at 155 West Kiowa Ave., Elizabeth, CO 80107]. All records requests and EFPD's responses must comply with the *Policy*; the Colorado Public (Open) Records Act, C.R.S. § 24-72-201, *et seq.*; and all other applicable law. EFPD will charge fees for its responses to a records request as provided in the *Policy*.

Person Requesting Records:

Full Name: _____ Date of Request: _____

Address: _____

Email Address: _____ Telephone: _____

Records Requested: Please list the documents you are requesting with as much specificity as possible. If known, include the type of document, a date or date range, the specific subject matter, and the names of persons or locations. Please attach additional pages if more space is needed.

Protected Health Information: If any of the documents you requested contain medical information protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be required to submit an *Authorization to Release Medical Information* (page 2) before EFPD can release the documents to you.

_____

_____

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Delivery Method for Copies of Records:

☐ I wish to inspect the records at EFPD's administrative offices at 155 West Kiowa Ave., Elizabeth, CO 80107, and do not want any copies of the records delivered to me.

☐ By pick-up at EFPD's administrative offices at 155 West Kiowa Ave., Elizabeth, CO 80107.

☐ By mail to the following address: _____

☐ By fax to the following fax number: _____

☐ By email to the following email address: _____

For Fax or E-Mail Delivery: If any of documents you requested contain medical information protected under HIPAA, you must complete and sign the section of the *Authorization to Release Medical Information* (page 2) entitled "***Authorization to Transmit via Electronic Means***" before EFPD can release the documents to you.

SIGNATURE: I hereby certify that I am the person requesting records as named above. I agree to pay all fees and costs incurred in responding to this request pursuant to EFPD's *Standard Operating Procedure for Open Records Requests* **before** the records are released to me.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

I, _____, authorize the Elizabeth Fire Protection District (EFPD) to release the following
Patient or Patient's Representative

records, including any Protected Health Information regarding the patient that the records contain:

_____

_____

_____

_____

Please list the documents you are authorizing for release with as much specificity as possible. If known, include the type of document, a date or date range, the specific subject matter, and the names of persons or locations. Please attach additional pages if more space is needed. **You must specifically authorize the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

The records listed above may be released to the following individual(s) or organization(s):

Name of Recipient: _____ Organization: _____

Address: _____

For the purpose of: _____

_____

OPTIONAL Authorization to Transmit via Electronic Means:

I hereby request that the records listed above be released to the recipient by fax or email, and not by U.S. mail or delivery service. I understand that the records will be sent through **unencrypted fax/email that is not secure** and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. EFPD is not responsible for unauthorized access of the records or Protected Health Information resulting from the faxed or emailed transmission, or for safeguarding the Protected Health Information upon delivery.

☐ By fax to the following fax number: _____

☐ By email to the following email address: _____

Expiration. Unless earlier revoked, this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.

Revocation. I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.

Patient Rights. I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

Re-disclosure. I understand that any disclosure of protected health information carries with it the potential for unauthorized re-disclosure, and may no longer be protected by federal confidentiality rules.

SIGNATURE: I understand that authorization for the disclosure of these records and the Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. I authorize photocopies of this release to be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____ Date: _____

Description of Personal Representative's Authority: _____