West Barnstable Fire District

2160 Meetinghouse Way
West Barnstable, Ma 02668

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_____ Minor Name_____ Guardian_____

Date of Service: _____

Medical Records _____ Fire/ accident report___ OTHER_____

Patient or representative Signature _____

Required for HIPAA release of information per 45 CFR s 164.514 (1) Standard: Verification requirements for protected health information.

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.