Lakeport Fire Protection District
445 N. Main Street, Lakeport, CA 95453
Phone: (707)263-4396 Fax: (707)263-7087 - www.lakeportfire.com

Authorization for Release of Patient Care Records

☐ I, _____, am requesting Lakeport Fire Protection District to disclose my Pre-Hospital Care records to i) ☐ self **or** ii) ☐ _____ as indicated below.

☐ I, _____, of _____ (your company), being a legal representative of _____ (patient name) am requesting **Lakeport Fire Protection District** to disclose Pre-Hospital Care records as requested below.

Incident Information	
Incident Number (if available):	**Incident Date (mm/dd/yyyy):**
Incident Time (h:mm am/pm):	**Incident Address/Location:**
Patient Name (PRINT):	
Information To Be Disclosed To	
Patient: ☐ **Legal Representative:** ☐ *(Must submit legal documentation such as HIPAA Release with this form)*	
Name (PRINT):	
Contact Address, City, State Zip:	
Phone:	**Fax:**
Method of Release	
Will be picked up in person (by person listed above): ☐ **Note: Photo identification (that has a signature) must be presented at the time of pick up**	
Via: Regular Mail: ☐ **Fax:** ☐ **Note: If requesting records via these methods and you are the patient, please have the completed form duly notarized before submission.**	

Revocation of Authorization

I understand that:

- I may withdraw or revoke my permission at any time with a written request. **The authorization will cease on the date the *written request* is received.**
- Any disclosures already made by Lakeport Fire Protection District, based on this authorization, cannot be retracted.
- Any information released by **Lakeport Fire Protection District**, based on this authorization, may be re-released by the person who receives it and may no longer be protected by Federal or Privacy regulations.
  - To revoke this authorization, I must submit a written request to: **Custodian of Records, Lakeport Fire Protection District**
    445 N. Main Street, Lakeport, CA 95453
    Phone: (707)263-4396 Fax: (707)263-7087

Signature of Patient

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. If requested, I will be provided a copy of this signed authorization. A photocopy of this authorization is as valid as the original.

Patient Name: _____ Signature: _____ Date _____

Signature of Patient/Legal Representative

If you are NOT the patient but are a legal representative (executor/conservator/administrator of will) requesting Pre-Hospital Care records of a patient, you must provide legal documentation (such as a HIPAA release form) that would allow Lakeport Fire Protection District to release such records to you.

Representative Name: _____ Signature: _____ Date: _____