Mt. Hope-Funks Grove Fire Protection District

Request Form for Fire/EMS Incident Report

I am requesting the Mt. Hope-Funks Grove FPD record types highlighted below:

☐ **INCIDENT REPORT.** Report created by the Incident Commander that complies with the rules of the National Fire Incident Reporting System (NFIRS).

☐ **FIRE INVESTIGATION REPORT.** Not all fires will have a Fire Investigation Report. Depending on the incident complexity and other factors a report may not be completed for weeks or months.

☐ **EMS/MEDICAL REPORT.** A patient authorization form is required if report contains confidential medical information and is requested by any party other than the patient or a court ordered subpoena of records. Court Orders do not require additional information, however, patients MUST provide photo identification before the report can be released. A copy of their photo ID shall be attached to the completed Fire/EMS Incident Request Form.

☐ **AMBULANCE BILL.** A bill following a transport from the scene of the incident to a hospital.

The information requested below must be completed in full. Requests without the required information will be returned to sender. If you do not have the necessary incident information, you may contact the Mt. Hope-Funks Grove FPD EMS Coordinator at (309)874-2532.

Please note: All incident report requests are generally processed within five (5) business days upon receipt. The Department may require additional time to process more difficult requests and if so, an estimated time frame will be provided to the requestor.

Please complete the following:

Requestor Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Incident Date: _____ Incident Time: _____

Incident Address: _____

Type of Incident: _____

Comments: _____

_____

Requestor Signature: _____ Date: _____

Please return this form, along with a valid HIPAA Authorization, supporting documentation signed by the patient, if applicable, to:

Mt. Hope-Funks Grove FPD
Attn: Records
PO Box 169
McLean, IL 61754

Fire Department Use Only
Incident Incident #: _____
Date Rcv'd: _____
Initials: _____

Mt. Hope-Funks Grove FPD

Emergency Medical Services (EMS) Report Request

Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq*. (2003)]

Emergency Medical Service (EMS) Reports

EMS reports are considered confidential medical records, and are protected by privacy laws. Please use the Authorization For Release of Protected Health Information form to request the record. A **clear legible** copy of photo identification (driver's license) must accompany and be attached to the request prior to release of the report.

Most third party requests require either a HIPAA authorization signed by the patient or a court order.

The Department may give a report for a deceased individual to the personal representative of the estate with completed Authorization For Release of Protected Health Information a copy of the death certificate and court order showing the appointment of the personal representative.

A report may be released to the guardian of a minor (with proof of legal guardianship), a healthcare decision maker (or an individual who is authorized to make health care treatment decisions for the patient. including the parent of a minor or an agent pursuant to a healthcare power of attorney) with completed Authorization For Release of Protected Health Information.

If you are requesting EMS records:

Mt. Hope-Funks Grove FPD
Attn: Records
PO Box 169
McLean, IL 61754

Mt. Hope-Funks Grove FPD

209 S. Hamilton St. McLean, IL 61754 (309) 874-2532

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq*. (2003)].

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

If you have questions about this authorization please contact the District at (309)874-2532.

Patient Information

Patient Name (first middle last): _____

Incident Date: _____ Incident Number (if known): _____

Incident Location: _____

Requesting Parties Information

Name of Requestor: _____ Phone: _____

Company/Organization: _____ Email: _____

Address: _____

Relationship to Patient:

☐ Parent of Minor ☐ Parent of Disabled Adult ☐ Legal Guardian ☐ Beneficiary ☐ Patient Authorized Representative

☐ Executor of Estate ☐ Power of Attorney ☐ Representing Attorney ☐ Law Enforcement ☐ Subpoena ☐ Spouse/Significant other

You MUST provide a copy of the legal authority you have to request medical information regarding the patient listed on the medical report. If the patient is deceased a copy of the death certificate must be included with request.

Format of Record Release

I request the record to be released in the following manner:

☐ In Person ☐ Mail ☐ Email ☐ Fax

Limitation on the Type of Information to Disclose

◯ No limitations on the type of information to disclose ◯ Limited to: _____

Patient Authorization

By submitting this form, I hereby voluntarily authorize the Mt. Hope-Funks Grove FPD to release this medical record.

As the patient, if I am authorizing the release of my medical record to the representative noted above. I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure.

I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. If you are the parent of a minor and represent as such, you agree to hold harmless the Mt. Hope-Funks Grove FPD from damages regarding the disclosure.

I hereby understand and agree that requests for electronic copies of my medical records from the Mt. Hope-Funks Grove FPD in electronic form via email may not remain confidential due to the unsecured nature of email transmission. I further understand and agree that the Mt. Hope-Funks Grove FPD, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system.

I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used of disclosed.

Patient Signature: _____ Date: _____

Or, Signature from Other/NOT Patient: _____ Date: _____

Relationship: _____ Date: _____

☐ I have been advised of my right to receive this authorization and request a copy of it when PCR is released.

Substantiating Information

Please submit the following with your request:

- A clear copy of your Driver's License or SOS-Issued Identification Card whether or not you are the patient. (Exceptions are made for Representing Attorney and Law Enforcement).
- Documentation of legal representation/responsibility if you are not the patient.

Submit this form to the address at the top of this page.