# City of Sycamore Fire Department

Authorization to Release Protected Health Information (PHI)

**Only a patient or a patient's authorized personal representitive may receive Protected Health Information.** To request medical treatment records (ambulance reports), please complete both pages of this form and submit them to the **City of Sycamore Fire Department**. Verification of identity (valid state issued photo ID) and/or official documentation (e.g., valid Health Care Power of Attorney or Will) may be required prior to any release of records

**EMS|MC** is contracted to manage ambulance billing on behalf of the City of Sycamore. To request assistance related to ambulance billing, please call **866-827-8469** or visit the **Chart Swap** online portal (http://www.chartswap.com).

## A – Patient information

Full Name _____ Date of Birth (mm/dd/yyyy) _____

Address _____

City _____ State _____ ZIP Code _____

Phone (_____) _____ Date(s) of service _____

Incident date/time _____

Incident location/address _____

Incident type or other details _____

Purpose of disclosure □ Personal/self □ Attorney/legal □ Healthcare provider

□ Other *(briefly explain)* _____

## B – Authorized personal representative *(complete only if applicable)*

Full Name _____ Firm/Agency (if applicable) _____

Address _____ Phone (_____) _____

City _____ State _____ ZIP Code _____

Relationship to the patient (select **one**):

☐ Parent/guardian of a patient currently under age 18 ☐ Patient's Health Care Power of Attorney

☐ Patient's estate executor/administrator ☐ Other *(briefly explain)* _____

Representative Signature _____ Today's Date _____

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## C – Delivery and format

Specify the delivery method and format of the records requested:

☐ Email to _____@_____

☐ Fax to (_____) _____

☐ Mail ***Paper / CD (circle one)*** to

Address _____

City _____ State _____ ZIP Code _____

☐ In-person inspection ~ ***Call to schedule during regular business hours 815-895-4514.~***

## D – Patient authorization

I authorize the City of Sycamore Fire Department to disclose my complete PHI records for the date(s) of service in **Section A**.

I understand that the above-named person/entity in **Section B**, if any, is authorized to receive this information and has the right to inspect and copy the information disclosed. I understand that if the person/entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by HIPAA Regulations.

I understand I may revoke this authoriziation. Revocation must be in writing, submitted to th City of Sycamore Fire Department. I understand no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

My signature below indicates this disclosure authorization is valid for twelve (12) months, unless an alternate expiration date is specified.

Patient Signature _____ Today's Date _____

*Alternate Expiration Date (optional)* _____