Charlottesville Fire Department

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial)  Social Security # or Patient ID

Street address, City, ST, ZIP Code

Primary phone number | Other phone number  Email address

Type of Request

☐ Access/copy  ☐ Amendment  ☐ Restriction

☐ Confidential communication  ☐ Accounting of disclosures  ☐ Confidential communication

☐ Accounting of disclosures  ☐ Complaint

As the person signing this consent, I understand that I am giving my permission to the Charlottesville Fire Department for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the person or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Please list Charlottesville Fire Department staff members contacted regarding this matter:

Name  Date

Name  Date

Name  Date

Signature  Date

For Administrative Use Only:

Action taken  Date received

Action taken  Date

Privacy Official signature  Date

Records Release for Deceased or Mentally Incapacitated Patient – see reverse

Attach additional documentation, if applicable.
Records Release for Deceased or Mentally Incapacitated Patient

If records are those of a deceased or mentally incapacitated patient:

First: to the personal representative or executor of the deceased patient or the legal guardian or committee of the incompetent or incapacitated patient

Second: If there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased patient in order of blood relationship

I certify that I am entitled to receive the requested record on the front of this form because the patient is deceased or incapacitated and there is no other person of higher priority (as set forth in the above paragraph) that is entitled to receive the record.

_____________________________________________________________________   ________________________
Signature of requesting party               Date

_____________________________________________________________________   __________________________
Printed Name of requesting party               Relationship to patient

For Administrative Use Only:

_____________________________________________________________________   ________________________
Action taken               Date received

_____________________________________________________________________   ________________________
Action taken               Date

_____________________________________________________________________   ________________________
Privacy Official signature               Date