Central Pierce Fire & Rescue
Mailing Address: PO Box 940, Spanaway, WA 98387
District Headquarters: 17520 22nd Ave. E., Tacoma, WA 98445
(253) 538-6400 FAX (253) 276-6770 Email: records@centralpiercefire.org

Request for Patient Care Records

Identification of Records: Incident Date:__________

1) Location/Address of Incident: ______________________________
2) Patient: Last ______________ First______________ MI ____
3) Patient Date of Birth: __________

Requestor:

Name: Last ______________ First______________ MI ____
Company: ______________________ **Phone:** ______________
Email Address: ______________________ **Fax:** ______________
Street / Mailing Address: ______________________________
City: ______________________ **State:**__________ **Zip:**__________

☐ Attorney / Legal ☐ Owner / Patient ☐ Personal Representative
☐ Guardian ☐ Media ☐ Other Agencies (i.e., Police, DSHS, Fire Marshal)

A photo ID of the Requestor is required to complete the request.

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information (PHI) in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other District policies, which you may have upon request. I understand that I have the right to revoke this Authorization at any time except to the extent that CPFR has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the District Privacy Officer.
I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law. I understand that my written authorization is not required to use my PHI for treatment, payment an dhealth care operations. I understand that I have the right to inspect and copy my PHI. The Authorization is being requested for the following purpose(s):

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By signing this form, I hereby authorize and direct the use or disclosure by Central Pierce Fire & Rescue of certain medical information (PHI) pertaining to my health, my health care, or me. I acknowledge that I have read the provisions in this form and that I have the right to refuse to sign this form. I understand and agree to its terms.

Date of Request: ______________ **Patient Signature:** ______________________

This authorization will expire 90 days from the date the request is signed.

For Office Use Only

Processed Date: ______________________ Incident # ________________

☐ Picture I.D. Verified Amount Paid:________ ☐ Cash ☐ Check #:________ Receipt #:________

☐ Request granted ☐ Record withheld ☐ Record withheld in part
☐ Mailed ☐ Faxed ☐ Picked up in person
☐ Secure e-mailed

CPFR Employee Signature: ______________________________