AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby request and authorize the Temple Terrace Fire Department to release the following records:

□ All General Medical Records
□ Limited records (specify) _____

Patient Name: _____

Date of Birth _____ Date of Service _____

Incident No. _____ Incident Location _____

For the purpose of:
□ Continuing to receive medical care □ Information for the insurance company
□ Information for attorney □ Personal use of the patient
□ Other (specify) _____

The foregoing records shall be disclosed to:

Name of person or agency _____

Address _____

City _____ State _____ Zip _____ Phone/Fax Number _____

Specific Understandings:

I understand that by signing this authorization, I authorize the Temple Terrace Fire Department to disclose the information identified above and related information necessary to accomplish the purpose described.

I understand that I will be required to provide the Department with identification and, if I am not the patient or parent thereof, other documentation as reasonably required by the Department to establish my legal authority to execute this authorization.

I understand that I may revoke this authorization at any time by submitting a written request to the Department, except to the extent that the Department has already taken action in reliance on this authorization. I understand if I do take action to revoke this authorization, it will expire automatically 60 days after the date of signature.

I understand that the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations and other privacy laws.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand that the Department charges 15 cents for each one-sided copy, 20 cents for two-sided copies for copies that do not exceed 14 inches by 8.5 inches, and $1.00 per page for certified copies.

The undersigned individual authorizes the release of records:

□ Patient □ Authorized representative
□ Parent □ Surviving spouse
□ Legal guardian □ Administrator/Executor of Estate
□ Other (specify) _____

Date signed _____ Signature of patient or authorized representative _____

Print Name of patient or authorized representative _____

A COPY OF THIS SIGNED DOCUMENT WILL BE PROVIDED TO THE PATIENT OR PERSONAL REPRESENTATIVE AND SHALL ACCOMPANY THE RECORDS DISCLOSED

REQUEST FOR PUBLIC RECORDS

I hereby request the records specified below:

- ☐ All Fire Records
- ☐ All Housing Records
- ☐ Limited records (specify) _____

Information: **Date of Service** _____

Incident Location _____

Incident Number _____

Notice: Completion of this form is not required to review or obtain copies of public records. However, completing this form completely and accurately will assist our staff in responding to your request for public records. Record requests are typically processed within 7- 10 days of the Department's receipt of your request, barring any unusual circumstance. If you need records sooner than this, please advise our staff and we will attempt to accommodate your request. For record request status, please call (813) 506-6708. If you would like us to notify you when records are available for pickup, please provide your contact information below.

Charges: The Department charges 15 cents for each one-sided copy and 20 cents for two-sided copies for copies that do not exceed 14 inches by 8.5 inches. For all other copies, you will be charged the Department's actual cost of duplication of the record. Certified copies of public records are available at a charge of $1.00 per page. If the nature or volume of your request requires extensive use of information technology resources or extensive clerical or supervisory assistance by Department personnel, the Department will impose, in addition to the actual cost of duplication, a service charge based on the cost incurred for such extensive use of information technology resources or the personnel cost of providing the service required to respond to your request. You will be notified in advance if any such service charge applies to your request.

Name _____

Phone Number _____

A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED