



PUBLIC RECORD REQUEST FORM

Name		Date
Primary Phone	Secondary Phone	
Fax	Email	
Address		
What public record is being requested?		<i>Typed requests may be submitted on a separate page</i>
Why are you requesting this report?		

Requests may be hand delivered, mailed, or faxed to Seaside Fire & Rescue at 503-717-9318

I understand that a fee of \$25.00 is required to be paid to the **City of Seaside 989 Broadway, Seaside OR 97138** prior to the release of a report.

Payment must be collected in advance before receiving any report.

If inquiring about personal or medical treatment information a signed release form must accompany this request signed by the patient (s) or guardian.

SIGNATURE: _____ DATE: _____

Fire Department Only - DO NOT WRITE BELOW THIS LINE - Fire Department Only

Payment received	Date	Records handled / submitted by:	Date
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HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for
 [The City of Seaside] to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check as appropriate:

I hereby disclose my complete health record, including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

I hereby disclose my complete health record except for the following:

- Mental health records
- Communicable diseases including, but not limited to, HIV and AIDS
- Alcohol/drug abuse treatment records
- Genetic information
- Other (Specify)

Form of Disclosure:

Electronic copy or access via a web-based portal

Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

a) From _____ to _____

Or

b) All past, present, and future periods

Or

c) The date of the signature in section VI until the following event:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: Fire Marshal / EMS Officer

Organization: Seaside Fire & Rescue (c/o The City of Seaside)

Address: 989 Broadway, Seaside, Oregon 97138.

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: