



SANTA CLARA FIRE DEPARTMENT

REPORT REQUEST FORM

Main Number (408) 615-4900 Fax Number (408) 246-8652

_____ Patient Care Report Authorization for Release of Medical Records

Address of Incident:

Date of Incident:

Comments:

Photo identification or other authorization for release of protected health information may be required.

Requestor's Name (First, Middle, Last):

Patient in this Incident? Yes No

Telephone Number:

Other:

If you are NOT directly involved in this incident, please complete the following:

Relationship to Incident/Investigation:

Spouse Parent/Guardian Attorney Insurance Agent

Other:

*Pursuant to the California Public Records Act, all requests for information will be processed within 10 days of the request. If additional time is required to fulfill the request for information, the the requesting party will be notified of any necessary delays. **There will be a 20¢ charge per page for photocopies. Upon notification, record information needs to be picked up within 30 days.***

Signature of Person Requesting Information:

Date:

OFFICE USE ONLY

Request Received by:

Date Received:

Report Copy Cost:

Request Approved by:

Date Approved:

Date Picked up:

Disposition:

Record Released Not Entitled to Record CAO Legal Service Request # _____

Active Investigation Referred to: _____

