City of Sycamore
Fire Department
535 DeKalb Ave. ■ Sycamore, IL 60178 ■ Phone (815) 895-4514 ■ Fax (815) 895-3376

Authorization to Release Protected Health Information

Patients may request copies of their own medical records from Sycamore Fire Department (SYFD). Verification of identity and/or valid official documentation may be requested prior to releasing records. *Please complete this form in its entirety, as blanks may delay the response or result in a denial, and submit both pages of this form to* ***Sycamore Fire Department, Attn: Ambulance Records, 308 W. State St., Sycamore, IL, 60178***.

Patients with questions or concerns about billing may contact Andres Medical Billing at 800-244-2345. Other billing record requestors, including aw firms, insurance companies, record retrieval agencies, and other legally authorized entities, may request billing records online via Chart Swap http://www.chartswap.com.

A – Patient information

Date of Birth (mm/dd/yyyy)

Full Name _____

Address _____

City _____ State _____ ZIP Code _____

Phone ( ) _____ Date(s) of service _____

Incident date/time _____

Incident location/address _____

Incident type or other details _____

Purpose of disclosure □ Personal/self □ Attorney/legal □ Healthcare provider

□ Other *(briefly explain)* _____

B – Authorized personal representative *(complete only if applicable)*

Firm/Agency (if applicable)

Full Name _____ _____

Address _____ Phone ( ) _____

City _____ State _____ ZIP Code _____

Relationship to the patient (select **one**):

□ Parent/guardian of a patient currently under age 18 □ Patient's Health Care Power of Attorney

□ Patient's estate executor/administrator □ Other *(briefly explain)* _____

Representative Signature _____ Today's Date _____

C – Delivery and format

Specify the delivery method and format of the records requested.

□ Email to _____@_____

□ Fax to (_____) _____

□ Mail ***Paper / CD (circle one)*** to Address _____

City _____ State _____ ZIP Code _____

□ In-person inspection ~ ***Call to schedule during regular business hours 815-895-4514.~***

D – Patient Authorization

I authorize SYFD to disclose my complete PHI records for the date(s) of service in **Section A**.

I understand that the above-named person/entity in **Section B**, if any, is authorized to receive this information and has the right to inspect and copy the information disclosed. I understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by HIPAA Regulations.

I understand I may revoke this authoriziation; however, revocation must be in writing and sent/given to SYFD. I understand no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

My signature below indicates this disclosure authorization is valid for twelve (12) months, unless an alternate expiration date is specified.

Patient Signature _____ Today's Date _____

Alternate Expiration Date (optional) _____