CITY OF KNOXVILLE FIRE DEPARTMENT

FIRE MARSHAL'S OFFICE

CITY COUNTY BUILDING
400 MAIN STREET ROOM 539-545
KNOXVILLE, TENNESSEE 37902
PHONE (865) 215-2283 / FAX (865) 215-4249

Authorization for Release of Medical Records
Request for EMS Report (Page 1 of 4)

The Emergency Medical Services (EMS) Report may contain confidential information including medical histories, reports of actions and findings, diagnoses, records of treatment, medications, and other material maintained by the Knoxville Fire Department pertaining to the individual receiving emergency medical care.

All information in Section 1 is required. In the absence of a court order, all forms bearing the signature of the patient or the patient's legal guardian must be notarized (page 3) if not signed in the presence of a City of Knoxville Representative with proper identification.

RECORDS MAY NOT BE RELEASED WITHOUT SIGNATURE OF PATIENT. If a patient is unable to sign (e.g., minor, deceased, physically or mentally incapacitated), a legally qualified representative may sign in lieu of patient by completing Section 2. The individual or entity must both provide proof of identity and proof of relationship to the patient. Copies of documentation may include a driver's license or other photo id.

The City of Knoxville will not release any document without proper authorization and identification in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA release form on page 4 may be used in conjunction with Section 2.

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Authorization for Release of Medical Records
Request for EMS Report (Page 2 of 4)

Section 1

Patient's Full Name: _____ Date of Birth: _____

Social Security Number: _____ Telephone Number: _____

Address: _____

Date of incident: _____

Address of incident: _____

Reason for obtaining report: _____

Patient's Signature or Reason
Patient is Unable to Sign: _____ Date: _____

Note: If Patient is not present at the Knoxville Fire Prevention Bureau at the time of signing, the signature must be notarized on Page 3.

RECORDS MAY NOT BE RELEASED WITHOUT SIGNATURE OF PATIENT. If a patient is unable to sign (e.g., minor, deceased, physically or mentally incapacitated), a legally qualified representative may sign in lieu of patient and Section 2 must be completed.

Section 2

Representative to receive report: _____

Proof of identity (attach copy): _____

Relationship to patient: _____

Proof of relationship (attach copy): _____

Signature of Representative: _____

For Internal Use Only

City of Knoxville Representative: _____

Title: _____ Report number: _____

Released to: _____ Date: _____

Signature of Recipient: _____

R061814

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Authorization for Release of Medical Records
Request for EMS Report (Page 3 of 4)

Before me, _____, on this day personally appeared _____ (patient's or legal representative's name), known to me (or proved to me on the oath of _____ or through (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he or she executed the same for the purposes and consideration therein expressed. In witness hereof, I hereunto set my hand and official seal.

State of_____

County of_____

_____
Notary Public- Signature

My commission expires: _____

SEAL

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Authorization for Release of Medical Records
Request for EMS Report (Page 4 of 4)

HIPAA Release of Information Authorization

Patient's Full Name: _____ Date of Birth: _____

Social Security Number: _____ Telephone Number: _____

Address: _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below to and by _____.
I hereby authorize such use and/or disclosure even though the information is or may be confidential, privileged, or otherwise protected from disclosure by federal or state laws and regulations. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations. I hereby release and discharge you of any liability, and will hold you harmless for complying with this authorization.

_____ I understand that this authorization expires one year from the date of my signature below.
(initial)

_____ I understand that I may revoke this authorization at any time by notifying the providing organization
(initial) in writing, except to the extent the organization has taken action in reliance on the consent.

_____ I understand that the persons hereby authorized to use or disclose information will not condition
(initial) treatment, payment, enrollment in the health plan, or eligibility for benefits on my providing this authorization, except in the case of research-related treatment.

_____ I understand that I may see and copy the information described on this form if I ask for it and that I get
(initial) a copy of this form after I sign it.

Organization providing the information: City of Knoxville Fire Department

Specific description of information (including date(s)):

_____

Patient or Patient's Representative		Witness	
Sign:	_____	Sign:	_____
Print:	_____	Print:	_____
Date:	_____	Date:	_____

If this Authorization is signed by a patient's representative, please provide the basis of the representative's authority to act for the patient (attaching a copy of any power of attorney, court order or other written authority)