CRESTED BUTTE FIRE PROTECTION DISTRICT
RECORDS REQUEST FORM

NOTICE: All records requests must comply with the Colorado Public (Open) Records Act, C.R.S. § 24-72-201, *et seq.*; and all other applicable law.

Person Requesting Records:

Full Name: _____ Date of Request: _____

Address: _____

Email Address: _____ Telephone: _____

Records Requested: Please list below the records you are requesting with as much specificity as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons or locations. Please attach additional pages if more space is needed.

Protected Health Information: If any of the records you are requesting contain health information protected from disclosure under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you must submit an *Authorization to Release Medical Information* (page 2).

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Delivery Method for Copies of Records:

- ☐ I wish to inspect the records at the District's administrative offices at 306 Maroon Ave Crested Butte CO, 81224 and do not want any copies of the records delivered to me.
- ☐ By pick-up at the District's administrative offices at 306 Maroon Ave Crested Butte CO 81224.
- ☐ By mail to the following address: _____
- ☐ By email to the following email address: _____

  For E-Mail Delivery: If any of records you are requesting contain health information protected under HIPAA, you must complete the section of the *Authorization to Release Medical Information* (page 2) entitled **"*Authorization to Transmit via Electronic Means*"** before the District can release the records to you.

SIGNATURE: I certify that I am the person requesting the records identified above. I agree to pay all fees and costs incurred in responding to this request pursuant to the District's *Resolution Establishing A Policy For Requests for Public Records And Assessing Charges for the Production of Public Records* **before** the records are released to me.

Signature: _____ Date: _____

For office use only:
Record release approved by: _____ Date: _____
Record distributed via: Fax Email USPS Picked up Incident number: _____

This form may be submitted via email office@cbfpd.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

I, _____, authorize the Crested Butte Fire Protection District ("District") to release the
Patient or Patient's Representative

following records, including any Protected Health Information regarding the patient that the records contain:

_____

_____

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Please list the records you are authorizing for release with as much specificity as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons or locations. Please attach additional pages if more space is needed. **You must specifically authorize the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

The records listed above may be released to the following individual(s) or organization(s):

Name of Recipient: _____ Organization: _____

Address: _____

For the purpose of: _____

_____

OPTIONAL Authorization to Transmit via Electronic Means:

I request that the records listed above be released to the recipient by fax or email, and not by U.S. mail or delivery service. I understand the records will be sent through **unencrypted fax/email that is not secure** and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. The District is not responsible for unauthorized access of the Protected Health Information resulting from the faxed or emailed transmission, or for safeguarding the Protected Health Information upon delivery.

☐ By fax to the following fax number: _____

☐ By email to the following email address: _____

Expiration. Unless earlier revoked, this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.

Revocation. I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.

Patient Rights. I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

Re-disclosure. I understand that any disclosure of Protected Health Information carries with it the potential for unauthorized re-disclosure, and may no longer be protected by federal confidentiality rules.

SIGNATURE: I understand that authorization for the disclosure of these records and Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. Photocopies of this authorization may be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____ Date: _____

Description of Personal Representative's Authority: _____