



**City of Hollywood Fire Rescue Department**  
**Request and Authorization for Disclosure of Health Information Form**  
**Mail to: 2741 Stirling Road, 3rd Floor, Hollywood Fl. 33312**  
**(954) 967- 4248 <http://www.hollywoodfl.org>**

Please process my request for Medical Record or other (specify) \_\_\_\_\_ In order to promptly fulfill your request, we would appreciate if you would provide us with the information listed herein: a copy of the applicant's photo ID, if applicable, a Power of Attorney, and Death certificate.

**ATTORNEYS ONLY:** For **ALL** medical record(s) and itemized bill(s) request, register at [www.Chartswap.com](http://www.Chartswap.com) or call 1-888-980-9234. To follow-up on medical record(s) or itemized bill(s) request, email [ClientSupportServicesMIA@R1RCM.COM](mailto:ClientSupportServicesMIA@R1RCM.COM).

**REQUESTING PARTY'S INFORMATION**

Name \_\_\_\_\_  
 Date of Request \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_ Apt./Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PATIENT INFORMATION**

Name on Report \_\_\_\_\_  
 Patient Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_, Patient SSN \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Location of Incident \_\_\_\_\_ Date of Incident \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Time of Incident \_\_\_\_\_ Incident Number (if known) \_\_\_\_\_

**In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a patient has the right to access, inspect and copy their Protected Health Information (PHI) maintained by Hollywood Fire-Rescue. Additionally, your rights allow you to request a copy, request to amend and/or request restriction of the use of any disclosure of your PHI.**

**This is an authorization requesting the City of Hollywood Fire-Rescue Department to release medical reports and/or information protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or by state law protecting the privacy of health information.**

**I \_\_\_\_\_ hereby authorize the use and disclosure of the individually identifiable health information to be furnished to the requesting party below.**

This authorization shall be in force and effect until \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires.

\_\_\_\_\_  
 Signature of Patient or Personal Representative Print Name

Relationship to Patient \_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

By \_\_\_\_\_  
 Personally known \_\_\_ or Produced Identification \_\_\_ Type of Identification Produced \_\_\_\_\_  
 (NOTARY SEAL)

\_\_\_\_\_  
 Notary Public