

**FREDERICK-FIRESTONE
FIRE PROTECTION
DISTRICT**



Administration
Office: (303) 833-2742
Fax: (303) 833-3736
WWW.FFFD.US

REQUEST FOR FIRE DISTRICT RECORD

Pursuant to the Frederick-Firestone Fire Protection District Records Release Policy, all requests for public information shall be made in writing by submitting this request form. Please Note: Public records are in various locations within the District. The District requires three business days to process requests for records. The District may require additional time to process difficult requests and if so, an estimated time frame will be provided to the requestor.

If you are requesting information regarding an emergency call and do not have the necessary call information, you may contact the Administration Office at 303.833.2742.

Record Information

Type of Record: ___ Incident Report: ___ Patient Care Report * ___ Other (Please Specify): _____

Specific items requested (i.e. page numbers, sections, etc.) _____

Address of Call: _____ Date of Call: _____

*** Patient Care Reports are protected health information. A Protected Health Information Access Request Form must be included for any patient information.**

Requestor Information

Name: _____ Company: _____

Street: _____ Unit: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Requestor Signature: _____ Supporting Identification: _____

Purpose of Request: _____

Special Instructions: _____

All requested records will be sent via USPS to the address listed below, unless otherwise specified and agreed to.

“I understand that the information I have requested is protected under the Health Insurance Portability and Accountability Act (HIPPA) and that transmission of this information by fax or email is not secure and it is possible the health information might be able to be seen by third parties. I authorize the Frederick-Firestone Fire District’s representative processing my request to transmit the requested documents by:

(Check One): Electronic Format: CD: _____ Flash Drive: _____ E-Mail: _____ Fax: _____

Signed _____ / _____ / _____
(Authorized Requestor) Printed Name Date

FIRE DISTRICT USE ONLY

Date Received: _____ Date Processed: _____ By: _____

FFFPD Number: _____ Patient Care Number: _____ FFFPD: _____ TAAD: _____

Invoice Prepared: ___ Yes: ___ No (Explain) _____

Payment Received: Yes: ___ No: ___ Amount Received: _____

Records Sent Via: Picked-up: ___ Mail: ___ Fax: ___ E-mail: ___ Other: _____



Protected Health Information Access Request

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____ Date of Service: _____

***Patient Rights:** As a patient, you have the right to access, copy or reinspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices.*

To better allow us to process your request, please indicate the type of request you are making on this form: **[Check all that apply]**

_____ Access to simply review my health information.

_____ Access to obtain copies of my health information.

_____ Access to review and potentially request restrictions on the use and disclosure of my health information.

Patient Signature _____ *Date* _____

Patient's signature may be witnessed and verified by a FFFPD representative or must be notarized.

State of _____
County of _____
Signed and verified this _____ day of _____ 2022.
My commission expires _____.

(Notary Signature)
Seal/Stamp