



Bennett Fire Protection District 7

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Section 1 - Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Incident/Run #(if known): _____

Date(s) of Service: _____

Section 2 - Requestor Information: (Select One)

- Attorney/Legal Representative
- Law Enforcement

Agency: _____ Division: _____

Address: _____
City State Zip

Phone: _____ Fax: _____

Section 3 - Legal Basis for Disclosure: (Check all that apply)

- Release of records to an attorney or law firm

I authorize Bennett-Watkins Fire Rescue to disclose my protected health information (PHI) to the attorney or law office listed below for use in a legal matter, claim, or proceeding.

Attorney/Firm: _____

Case/Reference No.: _____



Release of records for a court case or administrative proceeding

I authorize BWFR to disclose my PHI in connection with a court case, subpoena, administrative hearing, or workers' compensation matter. I understand that a valid legal process or proof of authority may be required.

Release of records to an insurance carrier / TPA

I authorize BWFR to disclose my PHI to the following insurer/claims administrator for claim review, appeals, or reimbursement:

Insurance/TPA Name: _____

Disclosure to law enforcement with proper authority

I am requesting that BWFR release records to a law enforcement agency in connection with an investigation, report, or other official matter. I understand that BWFR may require a subpoena, warrant, court order, or documentation of an applicable HIPAA exception.

Law Enforcement Agency: _____

Officer/Detective: _____ Badge #: _____

Verification of treatment/transport only

I am requesting that BWFR confirm the date(s) of service, location of incident, and whether I was treated and/or transported — no clinical details.

Accounting / clarification of prior disclosures

I am requesting information about whether my PHI has already been disclosed to law enforcement, an insurer, or another third party, as permitted by HIPAA.

Section 4 - Records Requested (check all that apply)

EMS Patient Care Report (PCR)

Billing/Claims Records

Other (describe): _____

Section 5 - Delivery Method

Preferred Format:

Paper (Mailed)

PDF

Fax

Recipient Email/Fax: _____

Section 6 — Notices & Disclaimers



Minimum Necessary: BWFR will limit disclosures to the minimum necessary to accomplish the stated purpose.

Verification: BWFR must verify the identity and legal authority of the requestor. Government photo ID and credentials may be required.

Fees: Reasonable, cost-based fees may apply for copies, media, redaction, and mailing, per 45 CFR §164.524(c)(4).

Turnaround: Standard processing times apply of 24-48 hours

Section 7 — Signature & Certification

- I certify that I am authorized to receive the requested records and that the legal basis checked above is accurate.
- I understand unauthorized use or disclosure of PHI may violate federal and state law.

Signature (Attorney/Law Enforcement): _____

Printed Name: _____

Date: _____

For District Use Only:

Date Received:

Time Received:

Date Completed:

Time Completed:

Completed By:

Delivery Method:

Summary of Response: _____
