EMS Records Custodian
Los Angeles Fire Department
200 North Main Street, 1620
Los Angeles, CA 90012

(Official Use Only)
Received On: _____
Incident Date: _____
Account Number: _____
RTS Number: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(45 C.F.R. §164.508(c) and 514(h))

Terms and conditions of this authorization - I understand that:

- By signing this document I am authorizing LAFD to use or disclose my Protected Health Information (PHI), for the purpose stated herein, which may contain personal, medical, and billing information collected in relation to the emergency medical service(s) provided by LAFD.
- The person(s)/organization(s) authorized to receive my PHI may not further use or disclose this information without specific written authorization from me or as otherwise specifically required or permitted by law (Cal. Civ. Code § 56.13).
- Unless revoked earlier, this authorization will end on the date/condition/event specified in Section "C" below.
- I may revoke this authorization by providing written notice to LAFD, except to the extent that action has been taken in reliance upon this authorization.
- LAFD may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

A. Patient Information (All fields in this section are REQUIRED, unless noted otherwise)

Name: _____

Birth Date: _____ SSN _____ / _____ / _____

Phone (Day) _____ (Evening) _____

Address: _____
Street Apt#

_____
City State ZIP Code

Email (optional): _____

B. Person/Organization authorized to receive the PHI - Please tell us who you are authorizing to receive your PHI by completing the information below. For "Relationship" please provide a general description such as "self", "spouse" or "attorney."

Name (required):_____ Relationship (required): _____

Phone - Day (required) _____ Evening _____

Email: _____

Address (required): _____
Street Apt#

_____
City State ZIP Code

C. Authorization Duration

- The "Start Date" is the date that this authorization will begin. If "Start Date" is left blank, the date the authorization was signed in Section G will be the "Start Date."
- The "End Date" is the date that this authorization will end. If "End Date" is left blank, this authorization will remain valid for one (1) year, until the condition set forth below ("Termination Condition/Event") has been met, or until we receive a written revocation from you.
- The "Termination Condition/Event" will automatically revoke this authorization.

Start Date: _____ End Date: _____

Termination Condition/Event: _____

D. Description of information to be released (please provide a description that is specific and meaningful) - I hereby authorize LAFD to release the following PHI:

Incident Date (required): _____ Incident/Account Number: _____

Incident Location: _____

Description of information to be released (required): _____

_____

E. Purpose for which this release is to be made (NOTE: You are not required to provide a specific purpose; if left blank, LAFD will presume that the release is simply being made at your request):

_____

_____

F: Patient Representative - If you are signing this authorization as a personal representative of the patient, please state your relationship:_____

***Required Documentation** – All patient representatives must submit copies of official documentation evidencing their authority to act on behalf of the patient (e.g. birth certificate for parent of a minor, Medical Power of Attorney or Advance Health Care Directive, court order granting guardianship of a patient, etc.) All submitted documents are subject to verification.*

G: Your Name and Signature (All fields in this section are REQUIRED).

Name (Print): _____

Signature: _____ Date: _____

By signing this document I declare under penalty of perjury that all statements contained in this form and accompanying document(s) are true and correct.

H: Identity Verification (45 C.F.R. § 164.514(h)) – You (the person identified in Section G) must check (✓) ONE of the boxes below and comply with the requirement of your selection.

1) ☐ Attached is a copy of my photo identification which shows my signature (acceptable identification is a State Driver's License, State Identification Card, Passport, Matricula Consular, or City, State, or Federal Employment ID Card).

OR

2) ☐ No photo identification is attached but my signature has been notarized below.

Notarized By: _____ On (Date): _____

Notary Public Number: _____
(Unofficial Unless Stamped By Notary Public)

Print **Clear Form**

Please return this form and supporting documents to the following address:

Los Angeles Fire Department
Attention: EMS Records Custodian
200 North Main Street, 1620
Los Angeles, CA 90012

OR

Email: LAFD.EMSRecords@lacity.org
FAX (213) 978-3813

If you have questions, need additional information or assistance in completing this form, please contact us at the above address or call (213) 978-3648.