



Pullman Fire Department

620 S Grand Ave., Pullman, WA 99163

Phone: (509) 338-3271 ♦ Fax: (509) 332-4460



Emergency Medical Services Ambulance Transport

Patient Consent for Disclosure and Release Affidavit of Pre-Hospital Medical Records

This form is required for the disclosure and release of patient medical records and must be completed by the adult Patient, Parent, or Legal Guardian of a minor-age child. Submitting this document electronically requires the requestor's signature to be witnessed and verified before a Notary Public.

If choosing to pick up records in-person, you may do so by completing this form and presenting a valid government-issued photo ID (e.g., State Driver's License, State Identification Card, Passport, or City/State/Federal Employment ID Card) to Pullman Fire Department- 620 S. Grand Ave. Pullman, WA 99163.

Electronic Records Request No. (if known): _____

Patient Full Legal Name: _____ Date of Birth: _____

If requesting medical records on behalf of a minor-age child, please include your full name below:

Parent/Legal Guardian Full Legal Name: _____

Address: _____ SSN: _____

Phone Number: _____ Email: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I also understand that:

1) Authorizing the disclosure and release of this healthcare information is voluntary; 2) I can cancel this authorization at any time by writing to the Pullman Fire Department; 3) Once the information has been released according to the terms of this authorization, the information cannot be recalled; 4) Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. Therefore, I understand that the person or organization to whom I forward my healthcare information may have the legal right to disclose this information to other people or organizations without my knowledge or consent; 5) Requesting copies of my healthcare records in electronic format from Pullman Fire Department (by way of GovQA/Granicus portal) may not remain confidential due to the nature of email transmission. I further understand and agree that the Pullman Fire Department, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an email system; And, 6) I have been offered a copy of the Pullman Fire Department Notice of Privacy Practices and advised this document is available on the Pullman Fire Department website, and I can request a printed copy free of charge by calling (509) 338-3271.

Medical Information Requested:

Complete Medical Record for the date range of: _____ to _____

My health information related to a specific treatment or condition: _____

My health information only for the following date(s) or transport #: _____

The Pullman Fire Department is hereby specifically *authorized to release* all information from my healthcare record(s) maintained by the department relating to all diagnosis, testing, or treatment unless hereto specifically excluded:

(Exclude by checking a box or boxes) HIV AIDS Mental Health Alcohol/Drug Use

Furthermore, as the patient, and by submitting this form, I hereby authorize Pullman Fire Department through its employees and/or agents the authority to release my personal healthcare information as directed in this medical records request to the named person below.

First Name: _____ Middle: _____ Last: _____

Relationship to Patient: _____

Organization or Business Name: _____ Title: _____

Address: _____ Phone: _____

This disclosure and release are being made for the following purpose(s): _____ and as such, the authorization provided herein shall expire immediately after the release and disclosure and may be used only for the purpose(s) specified.

I hereby consent to the release of the specified information and acknowledge I have fully reviewed and understand the contents of this authorization form.

Signature: _____ Date: _____

(Patient-Parent-Legal Guardian of Minor Child)

(See Reverse for Notary Public Section)

Records will be released by Pullman Fire Department once Proof of Identification has been presented, verified, and all fees for records have been paid.

FOR OFFICIAL USE ONLY

Government Issued ID Verified In-Person By:

Pullman Fire Department Staff: _____ Title: _____
(Signature)

Printed Name: _____ Date: _____

Notary Public Authentication Acknowledgment

Identification must be presented to a Notary Public (Notary completes this section)

State of _____ County of _____

I _____, a Notary Public, in and for the County and State above, do hereby declare that the affiant subscribed and sworn before me, _____ did appear personally before me, and who after being first sworn by me, affixed his or her signature and provided adequate identification proving their identity on this _____ day of _____, 20_____.

Signature of Affiant: _____

Identification Type and I.D. Number _____

AFFIX SEAL HERE

Notary Public Signature: _____

My Commission Expires: _____