SANTA CLARA COUNTY FIRE DEPARTMENT
1315 Dell Avenue, Campbell, CA 95008 • publicrecords@sccfd.org • (408) 378-4010

A California Fire Protection District serving Santa Clara County and the communities of Campbell, Cupertino, Los Altos, Los Altos Hills, Los Gatos, Monte Sereno, San Martin, Saratoga and the surrounding unincorporated communities.

Incident Report Request Form

REQUESTOR INFORMATION

Requestor Name: _____ **Phone: (_____) _____-_____**

Email: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip:** _____

INCIDENT INFORMATION

Incident Date: _____ **Incident Time:** _____ **Type of Incident:** _____

Incident Location (Street Address & City)**:** _____

Comments: _____

_____

_____

_____

I am requesting the Santa Clara County Fire Department record type(s) selected below (*check <u>all</u> boxes that apply)**:*

☐ NFIRS INCIDENT REPORT	☐ EMS/MEDICAL REPORT*
Report created by the Incident Commander that complies with the rules of the National Fire Incident Reporting System (NFIRS). • A fire investigation report may be included, however, not all fires will contain an investigation report. • Additional processing time may be required depending on the incident complexity and/or if there is a fire investigation report included. ***For NFIRS Incident Report, only page 1 needs to be included with the request.***	A patient authorization form (page 3) is required if report contains confidential medical information and is requested by any party other than the patient or a court ordered subpoena of records. Court orders do not require additional information; however, a patient MUST provide photo identification before the report can be released. A copy of their photo ID shall be attached to the completed Fire/EMS Incident Report Request Form. ****For EMS/Medical Reports, see page 2 for additional information. Pages 1 <u>and</u> 3 must be included with this request, along with required supporting documentation.***

Record Release: In an effort to conserve paper, County Fire sends incident reports via email in PDF format. If you do not have email access, please advise the records clerk at the time of your request. EMS/medical reports are available in hard copy format only (available via pick up or mailed via USPS).

Turnaround time: Requestors will be contacted when their request is received. Report requests are typically fulfilled within 10 days of receipt. When a fire is involved, the reporting process can take longer and may exceed the 10-day turnaround.

Requestor Signature: _____ **Date:** _____

Requests can be sent via:

1. **Mail**: Santa Clara County Fire Department, Attn: Records
   1315 Dell Avenue, Campbell, CA 95008
2. **E-mail:** publicrecords@sccfd.org
3. **Fax:** (408) 341-4499 (Attn: Records)

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Emergency Medical Services (EMS) Report Request

Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq.* (2003)]
California Confidentiality of Medical Information Act (CCMIA) [Civil Code § 56 *et seq.]*

Emergency Medical Service (EMS) Reports

EMS reports are considered confidential medical records, and are protected by privacy laws. Use the *(Authorization for Release of Protected Health Information pdf)* form to request the record. A **clear legible** copy of photo identification (driver's license) must accompany and be attached to the request prior to release of the report.

Most third-party requests require either a HIPAA authorization signed by the patient or a court order.

The Department may give a report for a deceased individual to the personal representative of the estate with completed *(Authorization for Release of Protected Health Information pdf)* a copy of the death certificate and court order showing the appointment of the personal representative.

A report may be released to the guardian of a minor (with proof of legal guardianship), a healthcare decision maker (or an individual who is authorized to make health care treatment decisions for the patient. including the parent of a minor or an agent pursuant to a healthcare power of attorney) with completed *(Authorization for Release of Protected Health Information (pdf)*.

Subpoenas from the District Attorney's Office do not require a HIPAA authorization signed by the patient.

If you are requesting EMS records:
Complete and submit the *Request Form for Fire/EMS Incident Report* and *Authorization for Release of Protected Health Information Form* by email at publicrecords@sccfd.org or mail to:

Santa Clara County Fire Department
Attn: Records
1315 Dell Avenue
Campbell, CA 95008

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Authorization for Release of Protected Health Information

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq.* (2003)] and the California Confidentiality of Medical Information Act [Civil Code § 56 *et seq.]*.

Review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization. Email the completed form and supporting documents to publicrecords@sccfd.org. Contact 408-378-4010 and ask to speak to the records clerk if you have questions about this form.

PATIENT INFORMATION

Patient Full Name: _____ **Incident Number** (if known): _____

Incident Date: _____ **Incident Location:** _____

REQUESTING PARTY INFORMATION

Requestor Full Name: _____ **Phone:** _____

Company/Organization: _____ **Email:** _____

Address: _____

Relationship to Patient: ☐Parent of Minor ☐Parent of Disabled Adult ☐Legal Guardian ☐Beneficiary
☐Executor of Estate ☐Power of Attorney ☐Law Enforcement ☐Subpoena
☐Patient Authorized Representative ☐ Spouse/Significant Other ☐Self

If you are not the patient, you MUST provide a copy of the legal authority you have to make medical decisions for the patient listed on the medical report. If the patient is deceased, a copy of the death certificate must be included with request.

SUBSTANTIATING INFORMATION

Submit the following with your request:

- A clear copy of your Driver's License or DMV-Issued Identification Card, whether or not you are the patient. *(Exceptions are made for Representing Attorney and Law Enforcement)*
- Documentation of legal representation/responsibility, if you are not the patient.

FORMAT OF RECORD RELEASE

I request the record to be released in the following manner:

☐ Mail ☐ Fax ☐ In-person pick up at SCCFD Headquarters

Limitation of the Type of Information to Disclose:

☐ No limitations on the type of information to disclose ☐ Limited to: _____

PATIENT AUTHORIZATION

By submitting this form, I hereby voluntarily authorize the Santa Clara County Fire Department to release this medical record.

As the patient, if I am authorizing the release of my medical record to the representative noted above, I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure.

I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. If you are the parent of a minor and represent as such, you agree to hold harmless the Santa Clara County Fire Department from damages regarding the disclosure.

I hereby understand and agree that requests for electronic copies of my medical records from the Santa Clara County Fire Department in electronic form via email may not remain confidential due to the unsecure nature of email transmission. I further understand and agree that the Santa Clara County 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 unsecured email system.

I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used of disclosed.

Patient Signature: _____ **Date:** _____

OR

Signature from Other (NOT patient): _____ **Date:** _____

I have been advised of my right to receive this authorization and request a copy of it when PCR is released.