CITY OF BREA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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

Name: _____

Date of Birth: _____ Last four of SSN: _____ Run Number (optional): _____

Address: _____

Telephone: _____ Email (optional): _____

Incident Date: _____ Incident Location: _____

B. Person/Organization Authorized to Release the PCR (Personal Care Report)

Name: _____

Address: _____

C. Person/Organization Authorized to Receive the PCR (Personal Care Report) – If you are requesting someone other than yourself to receive your PCR, please list who you are authorizing by completing the section below.

Name (Required): _____

Relationship (Required): _____

Address: _____

Telephone: _____ Email: _____

Unless otherwise revoked by the patient, this authorization for the release of the PCR to the above-named individual/organization will expire on the event or date specified below, or 12 months from the date in Part G.

Expiration Event: _____ Expiration Date: _____

D. Patient Representative – If you are completing this authorization on behalf of a patient, please indicate your relationship:

☐ I am the legal guardian.

☐ I am acting pursuant to a durable power of attorney.

☐ I am the conservator of the person.

☐ I am the executor or administrator of the estate of the person whose records are sought.

☐ I am a beneficiary of the estate of the person whose records are sought.

☐ Other (please describe) _____

**Please provide a copy of any document(s) that you have which grant you authority to request the patient's PCR (e.g. birth certificate for minor child, Medical Power of Attorney or Advance Health Care Directive, court order, etc.*

E. Health Records to be Released - General

I authorize the following records to be released:

❑ Medical Records ❑ Other

If Other, please specify: _____

F. Purpose for the Release or Use of the Information

❑ Health Care ❑ Personal ❑ Legal ❑ Other

If Other, please specify: _____

G. Your name and signature (REQUIRED):

- By signing this document, I am authorizing The City of Brea to use or disclose my Patient Care Report (PCR) which may contain personal and medical information collected in relation to the Emergency Medical Service(s) provided by Brea Fire Department.
- I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.
- I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part B. The revocation will prevent further release of my health information from the date of receipt.
- The party entered in Part C is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).
- If the party entered in Part C is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.
- I have a right to receive a copy of this authorization.
- Fees may be charged to cover the cost of releasing information.
- On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT.
- The foregoing is true and correct of my own personal knowledge. I declare under penalty of perjury that the foregoing is true and correct.

Executed at: _____ _____

(City, State) Date

_____ _____

Signature Printed Name

H. Identity Verification (REQUIRED) – Please provide one of the following:

☐ Attached is a copy of my government-issued photo identification which shows my signature.

If patient's name and/or date of birth on the patient care report (PCR) are discrepant with the photo identification provided, two forms of photo identification will be required. If two forms of photo identification are not available, one form of photo identification and a notary will be required.

or

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

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California, County of _____)

On _____, before me, _____, Notary Public

Personally appeared _____

who proved to me on basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf on which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

[Place Seal and/or Stamp above]

Signature of Notary Public

Please return this form and supporting documents to either of the following:

City of Brea
Attn: City Clerk
1 Civic Center Circle
Brea, CA 92821

OR

Save and submit request form to:

https://www.cityofbrea.gov/98/Public-Records-Request