

Orange County Fire Rescue Public Record Requests

Post Office Box 5879 Winter Park, Florida 32793-5879 Phone: 407.836.9050 / Fax:407.836.1919 FireRecords@ocfl.net

To Whom It May Concern:

Thank you for contacting Orange County Fire-Rescue regarding your request for EMS Patient Care Reports. Due to the federally directed Health Insurance Portability and Accountability Act of 1996 (HIPAA), requests for records containing protected health information (PHI) must follow a strict process to ensure that the individual requesting the health information is authorized to receive it.

Attached, you will find an Authorization for Release of Confidential or Protected Health Information form. Please fill this out as completely as possible. Note the following requirements to ensure your completed form meets satisfactory compliance in order for records to be provided in a timely manner:

- The individual filling out the form MUST BE the patient, or the individual with legal authorization to grant the release of the patient's protected health information (e.g. parent of a minor or legal representative of the estate of a decedent). For minor children we need a birth certificate attached to the request.
- Please enter by which method you are requesting receipt of these records (e.g. enter the email, fax number, street address with contact name or self, attorney's office, insurance company, etc.).
- The patient/representative must sign and print his/her name in the bottom section, enter date of birth and date of authorization. Law Firms must include a letter of representation as well.

You may email, fax, or mail to Orange County Fire-Rescue at the information contained in the header. Please be advised that you may receive Fire/Incident Reports in-person at 6590 Amory Court, Winter Park, FL 32792.

Please note that our retention for emergency records is seven years, and non-emergency is two years. Records prior to 2010 may require more time to locate due to system changes. Not all reports outside our retention schedule may be available.

The fees for copies of records per Orange County Administrative Regulations are \$0.15 per page, \$0.20 per double-sided copy, or \$1.00 per certified copy. An additional charge may be assessed to the actual costs of materials and supplies when the nature or volume of the records requested requires extensive* use of information technology resources, extensive clerical or supervisory assistance by County personnel. Records retrieval is estimated at five minutes per report from 2010 to the present, and approximately fifteen minutes per report prior to 2010 (if those records still exist). You will be billed at approximately \$17.29/hour for these reports.

* For the purpose of this Regulation, "extensive" shall mean that it will require more than 30 minutes to locate, review the records for confidential or exempt information, copy and refile the requested material. If you have any questions, concerns or would like additional clarification, please feel free to contact us at any time. Best Regards, Public Records Custodian Orange County Fire Rescue

Authorization to Disclose Protected Health Information

The undersigned authorizes $\underline{\text{Orange County}}$ Fire Rescue

(Facility name)

to release my health information as noted below:

***All sections must be completed in order for request to be processed *** Please email your request to "PublicRecordRequest@OCFL.net"

Patient Information						
Patient Full Name:	Date of Birth:					
Patient Address:	Other Names?					
City:	State:	Zip:Phone #:				
Release Information To (THIS SECTION I	MUST BE COMPLETED)					
Email address for record delivery: Please ensure email address is legible!						
You must provide a valid email address and name	of your designated recipient if	electronic deliv	ery is chosen.			
Name/Facility:		Attention:				
Address:		Phone:				
City:	State:	_ Zip:	Fax #:	·		
Purpose of Request: ☐ Personal ☐						
Information to be Released (THIS SECTION MUST BE COMPLETED) If you fail to specify, 1 year of records will be provided.						
· _						
At no time will the cost-based fees exceed FL law (395.3025 (1))						
Specify Date(s) of Service:		I understand	•	ble for the charges incu ted health information	rred in the release of my	
Body Part:			Patos aro dotorn	ained by Delivery Metho	nd Calactad	
☐ Other (please specify):		Rates are determined by Delivery Method Selected. *** PAYMENT OPTIONS: Check, Credit Card or Money Order				
		DELIVERY	[] Send by	[] Mail Records	[] Mail Records	
Questions about your request or invoice	ann ha answared his	METHOD	Email*	on CD	on Paper	
Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at 877-548-4069		*A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided				
on this form. No charge for records being released to another healthcare provider.						
Authorization to Release Protect						
I acknowledge and hereby consent to such, or AIDS information.*(Please		tion may conta	ain alcohol, drug	g abuse, psychiatric, F	IIV testing, HIV results,	
Lunderstand that:	: mitial)					
I may refuse to sign this authorization and	I that it is strictly voluntary					
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.						
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition:						
	-					
If I do not specify expiration this authorization will expire in 90 days. 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy						
regulations and may be disclosed.						
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.						
.,	, hava fillad aut this f	avea in ita a	ativoty if fo	um is incomplete	ov if protected	
Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.						
Signature*:			Date	:		
			- 			

Please provide a copy of your photo ID with the authorization
* For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy

of the legal documentation for patient's representative must be supplied with a copy of this form.