DeKalb Fire Department

Fire Station #1 | 700 Pine St. | DeKalb, IL 60115
Phone 815-748-8460 | **Fax** 815-748-8497

Authorization to Release Protected Health Information (PHI)

DeKalb Fire Department (DKFD) maintains patient care reports (also known as ambulance run reports), which may be requested **in writing by the patient or patient's authorized representative.** To protect patient confidentiality, verification of identity may be requested from the patient and/or authorized representative, such as Power of Attorney documentation.

Andres Medical Billing (AMB) provides ambulance billing services for DKFD and maintains billing records, which may be requested from AMB directly by calling 800-244-2345.

Please complete and submit both pages ***by mail to*** *DeKalb Fire Station #1 / 700 Pine St. / DeKalb, IL, 60115 ~OR~* ***by fax to*** *815-748-8497. Items left blank may result in a delayed and/or denial response. In general, patient care reports are provided within thirty (30) days of request receipt.*

Section A – Patient who received emergency medical services (EMS)

Name_____ Date of Birth_____

Address_____ Phone_____

City_____ State_____ ZIP Code_____

Email Address_____ Fax_____

Date(s) of service when patient received care_____

Section B – Recipient of record(s), if different from Patient

Name/Firm_____ Attention_____

Address_____ Phone_____

City_____ State_____ ZIP Code_____

Email Address_____ Fax_____

Relationship to patient_____

Section C – Description of record(s)

Date/Time of Incident (or approximation) Incident Address/Location

_____ _____

Other details that may assist in locating requested record(s)

_____

_____

Section D – Method of delivery and format

□ Email/electronic format □ Mail/paper format
□ Fax □ In-Person ***(please call 815-748-8460 to schedule)***

Section E – Purpose of disclosure

□ Personal □ Attorney/Legal
□ Healthcare Provider □ Other *(briefly describe)* _____

Section F – Authorization valid until date

Unless an earlier date is specified, this authorization will expire twelve (12) months from the patient's signature date below.

Calendar Date (Month/Day/Year)_____

Section G – Signature(s)

- I authorize DKFD to disclose my complete PHI records for the date(s) of service in Section A.
- I understand that the above-named person/entity in Section B is authorized to receive this information and has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by HIPAA Regulations.
- I understand I may revoke this authoriziation; however, **revocation must be in writing and sent/given to the DKFD**. I understand no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

Patient Signature_____ Date_____

Representative Signature_____ Date_____

Authority to represent patient

□ Self □ Parent (minor under age 18)
□ Guardian □ Power of Attorney
□ Authorized Representative *(briefly explain)* _____