PALISADE FIRE DEPARTMENT
OPEN RECORDS REQUEST FORM

NOTICE: All records requests must comply with the Colorado Public (Open) Records Act, C.R.S. § 24-72-201, *et seq.;* and all other applicable law.

Requesting Individual:

Full Name: _____ Date of Request: _____

Address: _____

Email: _____ Phone: _____

Records Requested: Please list below the records you are requesting with as much specificity as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons or locations. Attach additional pages if more space is needed.

_____

_____

_____

_____

_____

Protected Health Information: If any of the records you are requesting contain health information protected from disclosure under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you must submit an *Authorization to Release Medical Information* request as well (PAGE 2).

Delivery Method of Requested Records: *ONLY copies of Original Documents will be provided.*

☐ I wish to inspect the records at the Department's Administrative Office located at 175 East 3rd Street Palisade, CO. 81526, and do not want any copies of the records delivered to me.

☐ I will pick up copies at the Department's Administrative Office located at 175 East 3rd Street Palisade, CO. 81526. (Picture ID Required)

☐ By mail to the following address: (fees may apply)

_____

☐ By email to the following email address: _____

For email and/or fax delivery: If any of the records you are requesting contain health information protected under HIPPA, you must complete the section of the *Authorization to Release Medical Information* entitled "***Authorization to Transmit via Electronic Means"*** before the Department can release the records to you.

Signature: By affixing my signature I hereby certify that I am the person requesting the records identified above. I agree to pay all fees and costs incurred in responding to this request pursuant to the Department's *Resolution 17-08-0001 A Resolution Establishing a Policy for Requests for Public Records and Assessing Charges for the Production of Public Records* ***before*** *the records are released to me. I further acknowledge that subsequent requests for records shall require submittal of subsequent Open Records Requests and are subject to additional fees.*

_____ _____

Signature Date

FOR OFFICIAL USE ONLY:

Record Release Approved by: _____ Date: _____

Record Distributed via: ☐ FAX ☐ Email ☐ Mail Service ☐ Pick up ☐ On site viewing

This form may be submitted via email to krasier@townofpalisade.org

PALISADE FIRE DEPARTMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Last Name _____ First Name _____ MI _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address (If different than above) _____ City _____ State _____ Zip _____

I, _____, authorize the Palisade Fire Department ("Department") to
(**Patient or Patient's Legal Guardian)**
Release the following records, including any Protected Health Information regarding the patient that the records contain.

- ☐ My health information related to drug use, alcohol abuse
- ☐ My health information related to HIV/AIDS
- ☐ My health information related to psychological or psychiatric conditions
- ☐ My health information related to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

Indicate the records you are authorizing for release with as much specificity as possible, including type of record, a date or date range, the specific subject matter, and the names of persons or locations. Attach additional pages as needed. **You must specifically authorize the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

The indicated records may be released to the following individual(s) or organization(s):
Name of Recipient: _____ Organization: _____

Address: _____

For the Purpose of: _____

OPTIONAL Authorization to Transmit via Electronic Method:
I request that the above indicated records be released to the recipient by fax or email, and not by U.S. mail or delivery service. I understand the records will be sent through **unencrypted fax/email that is not secure** and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. The Department is not responsible for unauthorized access of Protected Health Information resulting from the faxed/emailed transmission, or for safeguarding the Protected Health Information upon delivery.

☐ By fax to: _____ ☐ By email to: _____

Expiration: Unless previously revoked, this authorization expires, with or without my express revocation, one year from the date of signing, or if on behalf of a minor on the date of becoming an adult according to state law.
Revocation: I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.
Patient Rights: I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

SIGNATURE: I understand that authorization for the disclosure of these records and Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. Photocopies of this authorization may be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Representative: _____ Date: _____

Description of Personal Representative's Authority: _____

This form may be submitted via email to krasier@townofpalisade.org