NORTH TAHOE & MEEKS BAY FIRE PROTECTION DISTRICTS

Return this form to:
Custodian of Records
North Tahoe Fire Protection District
P.O. Box 5879, Tahoe City, CA 96145
Fax: 530.583.6909 or kmartin@ntfire.net

REQUEST TO DISCLOSE PROTECTED HEALTH INFORMATION
Intra Departmental Disclosure

Name of person requesting disclosure	
Department	
Title	

Purpose for disclosure – mark 'X' adjacent to all applicable reasons

Court ordered subpoenas, warrants, summonses and or Grand Jury subpoenas	
Death Caused by Criminal Conduct	
Identification and or Location Purposes *(to locate and or identify a suspect, fugitive, material witness, and or missing person)*	
Victim of a Crime *(for the sole purposes of determining whether a crime occurred and or for the sole purposes of the continuance of a criminal investigation)*	
Custodial *(for the provision of the health care and or safety during the custody of the patient)*	
Reporting Required by Law *(in accordance with Placer or El Dorado County Department of Public Health and or Placer or El Dorado County Sheriff's Department - Coroner's Office)*	
Aversion of a Threat to Public Safety and or Public Health *(to apprehend and or identify person(s) who are wanted by Law Enforcement OR have made a statement to personnel admitting to a crime (past or future))*	
Healthcare Provision *(to provide healthcare to the patient and or its continuance through referral, third party providers, medical networks, and or insurance providers – to include billing for medical services)*	
Administrative Request from Police Department	
Other: please list reason for request to disclose patient health information *(Note: requestor must list the RELEVANCE & SPECIFICITY to identifiable information being requested)* *(to include Administrative Request from Police Department for investigation purposes only)* Write reason below or PD Case No. (as applicable)	

1

By signing below, I,_____, (print name) understand that requesting for the disclosure of patient health information, any of which may be used to identify a patient as such, for any reason other than marked above, is unlawful and is subject to penalty under both Health and Human Services, Office of Civil Rights and or California Department of Healthcare Services, Office of HIPAA Compliance. I acknowledge that I will engage in "minimum necessary" practices when working with said patient health information. I acknowledge that I will handle said patient health information in accordance with my Department's Records Policy and Procedure. Lastly, I acknowledge that I am requesting said patient health information apart from the consent of the patient (secondary to reason(s) listed above) and pursuant to said disclosure, will inform the patient and or their legal representative of said disclosure.

Print name: _____

Signature: _____ Date: _____

FOR FIRE DEPARTMENT ADMINISTRATIVE PURPOSES

Required materials prior to disclosure of patient health information – mark 'X' when completed

Copy of Department Identification (attach copy of ID) and include ID Badge No.	
Copy of Correlating Documents (list here or attach)	
Date of Disclosure *(patient health information, in the form of a printed electronic healthcare record are to be released in person to the requestor)* _____ **List PCR Incident & Sequence No(s).**	

End