City of Burnsville
FIRE DEPARTMENT

100 Civic Center Parkway
Burnsville, MN 55337-3817

(952) 895-4570
FAX: (952) 895-4512
www.burnsville.org

BURNSVILLE FIRE DEPARTMENT HIPAA PRIVACY AUTHORIZATION FORM

Authorization

I authorize Burnsville Fire Department to disclose and release the protected information records for

Patient Full Name _____

Patient Date of Birth _____

Date of Service(s)

This authorization for release of information covers the period from:

_____ to _____ OR ☐ All past, present, and future periods.

Address of Incident(s):

_____

to the following:

☐ SELF/ PATIENT "Patient" is defined as the patient, legal custodial parent(s) or legal guardians of a minor patient, a person the patient designates in writing as a representative, or health care agent.

☐ Electronic Record Request via GovQA, requires notarized signature

☐ I will pick up the records at Burnsville City Hall with a current picture id, paper copy fee is $.25 per page.

☐ Mail records to address below, requires fee to be paid and notarized signature

_____

(Name, Address, City and Zip Code records should be mailed)

- Deceased patient information may be obtained by submitting a copy of the death certificate and appointment of an executor of estate or similar legal authority and notarized signature, if picking up records in person picture id is required.
- For minors or children of divorced parents, the noncustodial parent should provide legal documentation and their notarized signature, if picking up records in person picture id required.

☐ OTHER

Name of Person/Company/Organization and Address of Whom I Authorize Burnsville Fire to Release Records, requires notarized signature

_____

(Print Name of Person/Company/Organization and Address)

☐ Electronic Record Request via GovQA, requires notarized signature

☐ Records will be picked up by person listed above at Burnsville City Hall with a current picture id, paper copy fee is $.25 per page.

☐ Mail records to address below, requires fee to be paid and notarized signature

_____

(Name, Address, City and Zip Code records should be mailed)

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Signature or Signature of Requesting Person Date

_____

Patient Printed Name or Printed Name of Person Requesting Person and Relationship to patient

_____ _____

Notary Public Signature Date

_____

Notary Public Printed Name

NOTARY PUBLIC STAMP