Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

DIVISION OF FIRE & RESCUE SERVICES
Administrative Services Section

Thomas E. Coe, Chief
Steve Leatherman, Deputy Chief

Frederick County Fire and Rescue Services
Patient Request for Access to Protected Health Information

FOR YOUR PROTECTION, ALL RECORDS REQUEST FORMS YOU SUBMIT (INCLUDING BILLING REQUESTS) MUST BE ACCOMPANIED BY A COPY OF YOUR VALID DRIVER'S LICENSE OR OTHER VALID GOVERNMENT ID. If any legally authorized person has requested Protected Health Information (PHI), we require a copy of that person's valid driver's license or other valid government ID along with documentation that they are legally authorized to act on our patient's behalf (such as a Power of Attorney). In limited circumstances, we may deny you access to PHI, and you may appeal certain types of denials by contacting the HIPAA Compliance Officer (Pamela Maliszewskyj) by emailing HIPAACompliance@FrederickCountyMD.gov or by phone at 301-600-1329). We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state or federal law.

Please be aware that after any authorized disclosure by DFRS, we are no longer responsible for the security of that information released to others. In other words, your health information may not be classified as Protected Health Information by the parties to whom you have authorized disclosure, and you may not be entitled to the protections for your personal health information that are afforded under federal and/or state privacy laws. To the extent that your request has not already been processed, you may cancel your request for disclosure by writing to the DFRS Custodian of Records at the address below or by emailing the DFRS Custodian of Records (EMSDocRequest@FrederickCountyMD.gov).

For all records requests, please complete the form located on the next page of this document and return that page to the DFRS Custodian of Records **(along with a copy of your valid identification and any documents authorizing you to request records for someone else)** using one of the following methods:

Encrypted email: EMSDocRequest@FrederickCountyMD.gov (with a Subject Line indicating either "Medical Records Request" OR "Ambulance Billing & Balance Question," depending on your needs)

or

USPS/US Mail to: DFRS Custodian of Records
(or in person) 5370 Public Safety Way
Frederick, MD 21704

or Fax to: 301-600-1323

We will process your request within 21 days or notify you of why we are not able to process your request.

Frederick County Fire and Rescue Services Patient Request for Access to Protected Health Information

Patient Name: _____ Date of Birth: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Email: _____

I authorize Frederick County Division of Fire and Rescue Services (DFRS) to release the following information from my DFRS medical record (Indicate any specific restrictions on disclosure here –if there are no specific restrictions listed, the record will be sent in its entirety):

____ **Treatment/medical record** for the following Date(s) Of Service/Incident _____ (to _____)
Restrictions (e.g., protected status such as HIV status, genetic condition, reproductive status, etc.): _____

____ **Billing and Payment records** for the following Date(s) Of Service/Incident: _____ (to _____)
Restrictions (e.g., protected status such as HIV status, genetic condition, reproductive status, etc.): _____

____ **Other** (describe) _____

I authorize the following person or organization to receive the information:

Name (*required*): _____
Mailing Address: _____
I prefer the records to be emailed/faxed to this email address/fax number: _____
I prefer my records be provided in the following alternate format: _____
The purpose of this disclosure is: __ At my request __ Other (describe): _____

This authorization will expire 90 days after the date of my signature, or sooner by choice, in which case this authorization will expire on _____, except to the extent action has already been taken in reliance upon this authorization.

I authorize the release of any information contained in my treatment and/or billing records that might contain sensitive information including information concerning diagnosis and/or treatment of alcohol or substance abuse, drug related conditions, mental health conditions, developmental disabilities, sexually transmitted diseases, communicable diseases, genetic testing, and/or HIV/AIDS related conditions.

I understand the treatment information released pursuant to this authorization could be subject to redisclosure by the recipient and may no longer be protected by federal law. If the information released pursuant to this authorization includes alcohol or drug treatment records, the person(s) receiving this information are hereby notified that federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.
I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that I may revoke this authorization at any time by notifying, in writing, the DFRS Custodian of Records (at the address listed below). I further understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that DFRS and its workforce are released from legal responsibility or liability for disclosing protected health information authorized by my signature below. DFRS reserves the right to send the record to the physical mailing address of the recipient if the medical record is too large to send/receive by email.

_____ _____
Printed name of Requestor Date

_____ _____
Signature of Requestor Relationship, if the Requestor is not the Patient

You may send your completed authorization by encrypted email to: EMSDocRequest@FrederickCountyMD.gov, by fax to 301-600-1323, or by USPS mail to DFRS Custodian of Records, 5370 Public Safety Way, Frederick, MD 21704. **PLEASE INDICATE IN THE SUBJECT LINES OF ANY EMAIL WHETHER YOUR REQUEST IS FOR "MEDICAL RECORDS" OR FOR "AMBULANCE BILLING/BALANCE RECORDS."**

Please allow 21 days for fulfillment or transfer of your medical records request. This is a general estimate and could require more or less time depending on several factors like when you were most recently treated by our team. If your medical records are needed for an important appointment or procedures with a physician's office, please plan with the fulfillment period in mind. To ensure we protect your patient information there is not a way to expedite the records fulfillment process. Records are kept for a limited time before they are destroyed.

Date Received: _____ ID validated: _____ Date Processed: _____
Notes: _____

Revised: 06/11/2024