Jacksonville Fire and Rescue Department

Duval County, Florida

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORD

Per City of Jacksonville Ordinance Code 94-624-487, the fee for a patient care report is $5.00, payable by check or money order to *City of Jacksonville Tax Collector*. Mail, fax, email or bring this completed form and payment to:

Jacksonville Fire and Rescue Department
Records Custodian
515 N. Julia Street
Jacksonville, FL 32202
Fax: (904) 630-4202
Email: JFRDRecordsRequest@coj.net

1. The patient information on this form must match the information documented in the patient care report.
2. A government issued ID is required if picking up records.
3. If any person other than the patient is signing this authorization, documentation of authority must be provided.

PATIENT INFORMATION

Patient Name: ______________________ Date of Request: ______________________

Patient Address: ______________________

City: ______________ State: ________ Zip Code: __________ Date of Birth: ______________

INCIDENT REPORT INFORMATION

Date of Incident: ______________ Incident Address: ______________________

AUTHORIZATION TO RELEASE TO A THIRD PARTY

I voluntarily consent to, authorize and request the Jacksonville Fire and Rescue Department to release a copy of my Patient Care Record for the date and location listed above to: **(THIS IS WHO YOU WANT YOUR RECORD GIVEN TO)**

Name of Recipient (Person, Practice, Company): ______________________

Address of Recipient: ______________________

City: ______________ State: ______________ Zip Code: ______________

Relationship to Patient: ☐Attorney ☐Relative ☐Media ☐Physician ☐Other ______________

Release record via: ☐Mail ☐Hold for pickup ☐Fax: ______________ ☐Email: ______________

I understand that by signing below, I am authorizing disclosure of information that may otherwise be protected by State and Federal law, including the Health Insurance Portability and Accountability Act of 1996. I also understand that information disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations. I understand that this authorization will not expire, however I may revoke this authorization at any time by notifying the Jacksonville Fire and Rescue Department in writing, and the revocation will be effective on the date notified (except to the extent that the record has already been released). This completed form will be retained by our personnel.

SIGNATURE

Falsifying an authorization to release medical information is a crime under federal law.

Patient/Parent/Legal Guardian Signature	Relationship	Date

FOR JFRD USE ONLY	Record Released by	Date	Receipt Number