Jacksonville Fire and Rescue Department

Duval County, Florida

FAMILY REQUEST FOR DECEDENT MEDICAL RECORD

Pursuant to 45 CFR § 164.510(b)(5) of the HHS Privacy Rule, covered entities may disclose protected health information to a person legally authorized to act on behalf of the deceased individual or his/her estate. The Privacy Rule also permits a covered entity to disclose a decedent's protected health information to a family member who was involved in the individual's health care or payment for care prior to the individual's death, or who is assisting with closing the estate. This may include disclosures to spouses, parents, children, domestic partners, other relatives, or friends of the decedent. Per City of Jacksonville Ordinance Code 94-624-487, the fee for a patient care record is $5.00, payable by check or money order to *City of Jacksonville Tax Collector*. Please 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 when picking up record.
3. Proof of authority to act on behalf of decedent and/or reasonable assurance of relationship to decedent is required.

PERSON MAKING REQUEST

Requestor's Name: ______________________ Phone: ______________

Address: ______________________________________

City: ________________ State: __________ Zip Code: __________

Relationship to Patient: ☐Spouse/Partner ☐Parent ☐Son/Daughter ☐Brother/Sister ☐Other/Relative

Are you involved in the decedent's care, payment for care or the closing of the decedent's estate? ☐YES ☐NO

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Patient Address: ______________________________________

City: ________________ State: __________ Zip Code: __________

INCIDENT INFORMATION

Date of Incident: __________ Incident Address *(if known)*: ______________________

TYPE OF REQUEST

Please indicate the type of request you are making: (check all that apply)

☐ I request to view the decedent's patient care report
☐ I request a copy of the decedent's bill
☐ I request a copy of the decedent's patient care report
☐ I request an accounting of who has seen the report

HOW DO YOU WANT YOUR REPORT SENT?

☐Mail ☐ Pick up in person ☐Fax: ______________ ☐Email: ______________________

SIGNATURE OF REQUESTING PERSON

Requesting Person's Signature	Date

JFRD USE ONLY	Record released by	Date	Receipt Number