Jacksonville Fire and Rescue Department

Duval County, Florida

PUBLIC HEALTH AUTHORITY DISCLOSURE REQUEST

Pursuant to 45 CFR § 164.512(b) of the HHS Privacy Rule, covered entities may disclose, without an individual authorization, protected health information to public health authorities authorized by law to collect and receive protected health information for the purpose of preventing or controlling disease, injury or disability, including, but not limited to, the reporting of disease, injury, or vital events, or for public health surveillance, investigations, or interventions. Public Health Authorities may mail, fax, email or deliver this completed form to:

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

1. Any patient information on this form must match the information documented in the patient care record.
2. An agency issued ID, official credentials or other proof of official status are required if picking up record(s).
3. All IDs except U.S. Government IDs will be photocopied.

REQUESTOR

Official's Name: _____ Agency ID/Badge #: _____

Agency: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

REQUESTED INFORMATION

Specifically describe the information you are requesting (include date ranges): _____

_____

_____

_____

_____

PUBLIC HEALTH PURPOSE

Specifically describe what the intended public health purpose is for your request: _____

_____

_____

PUBLIC HEALTH DISCLOSURE CHECKLIST

To ensure compliance with 45 CFR § 164.512(b)(1)(i), please check that the following criteria have been met:

☐ The requestor is a public health authority as defined in the HHS Privacy Rule 45 CFR 164.501

☐ The requestor has legal authority to collect/receive the requested information for the stated public health purpose

☐ The information being requested represents the minimum necessary to carry out the stated public health purpose

HOW DO YOU WANT THE RECORD SENT?

☐ Mail to: _____

☐ Agency Fax: _____ ☐ Agency Email: _____ ☐ In person

SIGNATURE

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

Requestor's Signature	Date

JFRD USE ONLY	ID Verified? ☐ Yes ☐ No	Record released by	Date