### BOARD OF FIRE COMMISSIONERS

2045 WANTAGH AVENUE WANTAGH, NEW YORK 11793

TEL. 516 785-1774 WANTAGH, NEW YORK 11

FAX 516 785-1041



# **Public Records Request**

Requests for records should be in writing using the appropriate forms. Please note the following:

- The application for Public Access to Records is required for all records request.
- If the records desired involve a request for assistance from the Wantagh Fire Department please complete the form and give as much detail as possible regarding the incident, the date, time, location and type of alarm(fire, rescue, auto accident, etc.).
- Oral request for records, though rarely, may be accepted when the records are readily available and do not include medical information.
- If you desire a copy of the Pre-Hospital Care Report (PCR), which is a medical record, the HIPPA Form <u>MUST</u> also be completed.

Address ALL requests:

Wantagh Fire District
Attn: District Superintendent Brendan J. Narell
2045 Wantagh Avenue
Wantagh, New York, 11793-3923
BNarell@WantaghFD.com

# Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

# Wantagh Fire District Application for Public Access to Records

<u>Directions:</u>
Please fill in the area below and please be as specific as possible. If this a request for an Alarm Report or Medical Record you **MUST** supply the DATE, TIME, LOCATION and ALARM TYPE.

PLEASE PRINT CLEARLY

I hereby apply	to inspect the following record(s):		
Signature	()_ Phone	Dat	e
Name (First an	nd Last)	Representing	
Mailing Addres	SS		
Return To:	Superintendent Brendan J. Narell Records Access Officer Wantagh Fire District 2045 Wantagh Avenue Wantagh, New York 11793		
	For Fire Dis	trict Use Only	
( ) Approved			
( ) Denied [se	e the reason(s) listed below]		
( ) Unwar	lential Disclosure ranted invasion of privacy d of which the Fire District is Legal lian but cannot be found	Part of Investigative File     Record is not maintained     Exempted by statute oth     Freedom of Information	d by the Fire District er than the
Signature	Title	 Dat	e
NOTICE:	YOU HAVE THE RIGHT TO APPE BOARD OF FIRE COMMISSIONE		
Name of Chair	man	Phone Number	
The Board of F	Fire Commissioners must decide the oppeal.	appeal in writing within (7) seven	working days of
I hereby appea	al:		
Signature		st and Last)	 Date

OCA Official Form No.: 960



## UTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		
I, or my authorized representative, request tl	at health information regarding my care and treatmer	nt be released as set forth on this form
	the Privacy Rule of the Health Insurance Portability	

- (HIPAA), I understand that:
- 1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV\* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL

CARE WITH ANYONE OTHER THAN THE ATTORNE	Y OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).			
7. Name and address of health provider or entity to release this				
Wantagh Fre District, 2045 Wantagh Avenue, Wan	tagh, New York 11793			
8. Name and address of person(s) or category of person to who	m this information will be sent:			
9(a). Specific information to be released:				
☐ Medical Record from (insert date)	to (insert date)			
	ice notes (except psychotherapy notes), test results, radiology studies, films,			
referrals, consults, billing records, insurance records,	and records sent to you by other health care providers.			
☑ Other: PCR	Include: (Indicate by Initialing)			
	Alcohol/Drug Treatment			
	Mental Health Information			
Authorization to Discuss Health Information	HIV-Related Information			
(b) ☐ By initialing here I authorize				
Initials	Name of individual health care provider			
to discuss my health information with my attorney, or a governmental agency, listed here:				
(Attorney/Firm Name or Governmental Agency Name)				
10. Reason for release of information:	11. Date or event on which this authorization will expire:			
☐ At request of individual				
Other:				
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:			
All items on this form have been completed and my questions	about this form have been answered. In addition, I have been provided a			
copy of the form.				

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Signature of patient or representative authorized by law.

Date: