KANSAS CITY KANSAS FIRE DEPARTMENT

EMERGENCY MEDICAL SERVICES DIVISION

Fire Headquarters
815 No. 6th Street
Kansas City, Kansas 66101

Office: 913-573-5550
Fax: 913-281-3655

REQUEST FOR INSPECTION OR COPY OF HEALTH INFORMATION

Patient Name:	Address:	Birth Date:

[☐] I request access to my health records in the possession of the Unified Government, Fire Department Medical Transportation Division, ("Department") (provided in accordance with standards required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")).

[☐] I request a copy of the health information in the Department's possession identified below:

- [☐] My medical records for the time period from _____ to _____
- [☐] My billing records for the time period from _____ to _____

- [☐] Identifiable information about me that was used by the Department to make medical decisions for the time period from _____ to _____.

[☐] I request a Summary of the above requested information, and understand that I will be charged a fee of $_____for this summary.

[☐] I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $_____ per page, plus a fixed charge of $_____.

[☐] I will pick up a copy of my records.
[☐] Please mail a copy of the requested records to: _____

- [☐] Paper Copy
- [☐] Electronic Copy (if available)

I understand that I may revoke this request at any time by providing the Department with my written notice of such revocation. **I have read and understand the above, and I agree to the terms hereof.**

_____ _____
Signature (Patient or Personal Representative) Date

Personal Representative Section
If a Personal Representative executes this form, that Personal Representative warrants that he or she has the authority to sign this form on the basis of:

[☐] Legal Authority (Power of Attorney, etc.) Please attach documentary evidence.
[☐] Parent, Guardian or other individual acting *in loco parentis*
[☐] Written Designation as Personal Representative by the Patient

If the Request is signed by a Personal Representative based upon "Legal Authority," adequate documentation of such Legal Authority shall be provided by such Personal Representative as requested by the Department.

FOR INTERNAL PURPOSES ONLY:

Date Request Received:_____

RESPONSE TO REQUEST FOR INSPECTION OR COPY OF HEALTH INFORMATION

RESPONSE TO REQUEST

[ ] Your request has been approved. We will provide the requested information within thirty (30) days after receipt of the request, or sixty (60) days for information that is not maintained onsite, from the date of this request unless we inform you that an extension is necessary. An extension will not exceed thirty (30) days.

[ ] Your request has been denied. The reasons for such denial and how you may have this decision reviewed or file a complaint are indicated on the form attached to this request.

Date: _____

Signature of Department Representative: _____