CLIFTON FIRE PROTECTION DISTRICT
OPEN RECORDS REQUEST FORM

NOTICE: All records requests must comply with the Colorado Public (Open) Records Act, C.R.S. § 24-72-201, *et seq.;* and all other applicable law.

Requesting Individual:

Full Name: _____ Date of Request: _____

Address: _____

Email: _____ Phone: _____

Records Requested: Please list below the records you are requesting with as much specificity as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons or locations. Attach additional pages if more space is needed.

Protected Health Information: If any of the records you are requesting contain health information protected from disclosure under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you must submit an *Authorization to Release Medical Information* request as well (PAGE 2).

_____

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Delivery Method of Requested Records: *ONLY copies of Original Documents will be provided.*

☐ I wish to inspect the records at the District's Administrative Office located at 3254 F Road Clifton, CO. 81520, and do not want any copies of the records delivered to me.

☐ I will pick up copies at the District's Administrative Office located at 3254 F Road Clifton, CO. 81520. (Picture ID Required)

☐ By mail to the following address: _____

☐ By email to the following email address: _____

For email and/or fax delivery: If any of the records you are requesting contain health information protected under HIPPA, you must complete the section of the *Authorization to Release Medical Information* entitled "***Authorization to Transmit via Electronic Means"*** before the District can release the records to you.

Signature: By affixing my signature I hereby certify that I am the person requesting the records identified above. I agree to pay all fees and costs incurred in responding to this request pursuant to the District's *Resolution 17-08-0001 A Resolution Establishing a Policy for Requests for Public Records and Assessing Charges for the Production of Public Records* ***before*** *the records are released to me. I further acknowledge that subsequent requests for records shall require submittal of subsequent Open Records Requests and are subject to additional fees.*

_____ _____

Signature Date

FOR OFFICIAL USE ONLY:

Record Release Approved by: _____ Date: _____

Record Distributed via: ☐ FAX ☐ Email ☐ Mail Service ☐ Pick up ☐ On site viewing

This form may be submitted via email to cbalke@cliftonfire.com

CLIFTON FIRE PROTECTION DISTRICT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information:

Last Name	First Name	MI	Date of Birth

Street Address	City	State	Zip

Mailing Address (If different than above)	City	State	Zip

I, _____, authorize the Clifton Fire Protection District ("District") to
(**Patient or Patient's Legal Guardian)**
Release the following records, including any Protected Health Information regarding the patient that the records contain;

_____

_____

_____

_____

Indicated the records you are authorizing for release with as much specificity as possible, including type of record, a date or date range, the specific subject matter, and the names of persons or locations. Attach additional pages as needed. **You must specifically authorize the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

The indicated records may be released to the following individual(s) or organization(s):
Name of Recipient: _____ Organization: _____

Address: _____

For the Purpose of: _____

OPTIONAL Authorization to Transmit via Electronic Method:
I request that the above indicated records be released to the recipient by fax or email, and not by U.S. mail or delivery service. I understand the records will be sent through **unencrypted fax/email that is not secure** and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. The District is not responsible for unauthorized access of Protected Health Information resulting from the faxed/emailed transmission, or for safeguarding the Protected Health Information upon delivery.

☐ By fax to: _____ ☐ By email to: _____

Expiration: Unless previously revoked, this authorization expires, with or without my express revocation, one year from the date of signing, or if on behalf of a minor on the date of becoming an adult according to state law.
Revocation: I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.
Patient Rights: I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

SIGNATURE: I understand that authorization for the disclosure of these records and Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. Photocopies of this authorization may be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Representative: _____ Date: _____

Description of Personal Representative's Authority: _____

This form may be submitted via email to cbalke@cliftonfire.com